

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

Reg. Dist. No. 03881 2.6

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 hrs + 55 min.
Hospital, institution, or street address where death occurred:
Suburban Hospital-Bethesda md.
How long in hospital or institution? 34 hrs +

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8705 Garfield
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Mr John A. Anderson

3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced m

6. (b) Name of husband or wife Jo Hanson

7. Birth date of deceased (mo., day, yr.) 2-12-71 6. (c) If alive, give age..... years

8. AGE: Years 75 Months 2 Days 6 If less than one day..... hrs. min.

9. Birthplace Tromsøars Sweden
(Town, county, and state)

10. Usual occupation Retired (Carpenter)

11. Industry or business.....

12. Name Anderson, Anderson

13. Birthplace Talsand Sweden

14. Maiden name Majastina

15. Birthplace Talsand Sweden

16. Informant Tipson - C. A. Johanson

Address 8705 Garfield St Bethesda

17. Removal Date thereof 4/18/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Creek Ave

Location Washington DC

18. Funeral director S. H. Hines & Co.

Address 2901-14th St. N.W. Wash, D.C.

19. 4/18 46 Mr E Jones
(Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-18 19 46 at 4:59 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 20 19 46 to April 17 19 46

and that I last saw him alive on April 17 19 46

Immediate cause of death Respiratory failure

Due to Cardiac Failure

Due to Hypertension and Aneurysm

Other conditions Fibrillation

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Frank Jagers MD M. D. or other

Address 8016 Georgetown Rd Date signed 4/18/46

MARGIN RESERVED FOR BINDING

VS-A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 25 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7-8)

CERTIFICATE OF DEATH

03882

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? since Dec. 5, 1945

Hospital, institution, or street address where death occurred:

Suburban Hosp. - Bethesda md.How long in hospital or institution? 16 days + 4 hrs +

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. 106 M. Adams
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Jean Hester Barnes

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced6. (b) Name of husband Wilbur J. Barnes

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 19218. AGE: Years 24 Months 4 Days 18 If less than one day hrs. min.9. Birthplace Clearwater, Idaho
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name James Wray13. Birthplace Philadelphia Pa.14. Maiden name Maude Clark15. Birthplace Blackfoot Idaho16. Informant King Rinder

Address

17. Removal Date thereof April 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory to

Location

18. Funeral director W. W. Chambers CoAddress 3072 - 7th St. N.W.19. 4/25 46 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 19 46 at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 7 19 46 to April 25 19 46and that I last saw him alive on April 24 19 46

Immediate cause of death

various veins of fatty tissue ofstomach with massiverepeated hemorrhage.Due to repeated hemorrhage.Disease Acute induritis -Exfoliating hemorrhage

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm E. Jones M.D.Address Rockville, Md Date signed 4/25/46

RECEIVED

APR 29 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03883

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hour
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D.C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1026 8th Street, N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3.(a) FULL NAME

BAYLOR, Melchie

3.(b) Social Security Number

4. Sex male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Jan 2, 1887 6.(c) If alive, give age _____ years

8. AGE: Years 59 Months 3 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Va.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant nephew: Mr. Urbene Baylor

Address 306 Canel Street, Fredericksburg, Va.

17. removal Date thereof 4-29-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Fredericksburg, Va.

18. Funeral director W. Ernest Jarvis LH

Address 1432 U St., N. W., Wash. D.C.

19. 4-29 46 Mary Charlotte Smith
(Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 April 19 46, at 11:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 April 19 46, to 28 April 19 46
and that I last saw him alive on 28 April 19 46

Immediate cause of death Massive pleural effusion

Due to Carcinoma of the lung with metastases

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results Ca of lung - metastases & pleural effusion

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? _____

Means of injury B.F. Eckardt Injured at work?

23. SIGNATURE B. F. ECKARDT, Lt. Cdr. (MC) USNR
M. D. or other

Address US NH Bethesda, Md. Date signed 4-29-46

RECEIVED

MAY 3 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

03884

Reg. Dist. No. 211

FILM No. I O 4 JUN - 4 1946

1. PLACE OF DEATH:

County Montgomery

City or town Damascus
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Damascus
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Echel Marion Beall

3.(b) Social Security Number

2

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Franklin E. Beall

7. Birth date of deceased (mo., day, yr.) Aug. 21 1871

6.(c) If alive, give age _____ years

8. AGE: Years 74 Months 7 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Dr. Benjamin P. Longdale

13. Birthplace Washington D.C.

14. Maiden name Emma Smith

15. Birthplace Maryland

16. Informant Mrs. John P. Lewis

Address Damascus, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof April 29, 1946
(month) (day) (year)

Cemetery or crematory Damascus, Md.

Location Damascus

18. Funeral director J. B. Beall, Inc.

Address Damascus, Md.

19. (Date rec'd by registrar) April 27 46 Registrar Desha V. Burdett

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1946 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to Apr 26 1946

and that I last saw him alive on Apr 25 1946

Immediate cause of death Coronary Infarction

DURATION

12 hrs.

Due to Chronic Pneumonia

Arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide no Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Kenyon H. Wyman M. D. or other

Address Laytonville Md Date signed Apr 26 46

RECEIVED
MAY 2 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-9)

CERTIFICATE OF DEATH

03885

Reg. Dist. No. 214

1. PLACE OF DEATH:

County... Montgomery
 City or town... Kensington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 months
 Hospital, institution, or street address where death occurred:
22 Prospect St.
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery
 City or town... Kensington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 22 Prospect St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3. (a) FULL NAME

Louis Henry Bosse

3. (b) Social Security Number

248-24-4865A

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Nannie Bosse
 6.(c) If alive, give age — years
 7. Birth date of deceased (mo., day, yr.) May 23, 1864
 8. AGE: Years 81 Months 10 Days 13 If less than one day — hrs. — min.

9. Birthplace Spartanburg, South Carolina
 (Town, county, and state)

10. Usual occupation Printer - retired

11. Industry or business

12. Name Christian Louis Bosse

13. Birthplace Germany

14. Maiden name Mary Jane Wooten

15. Birthplace Spartanburg, S. Carolina

16. Informant Mrs. B. P. Ransom

Address 22 Prospect St., Kensington, Md.

17. CREMATION — Date thereof 4-5-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory FORT LINCOLN

Location PRINCE GEORGES CO. MD

18. Funeral director Darwin E. Pumphrey

Address SILVER SPRING, MD.

19. April 5 19 46 Josephine M. Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 46 at 10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 19 44 to April 5 19 46
 and that I last saw him alive on April 5 19 46

Immediate cause of death Coronary occlusion DURATION 5 days

Due to Cardio-vascular-renal disease over 40 yrs.

Due to —

Other conditions —
 (Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Katharine A. Chapman MD

20 West Baltimore St. M. D. or other —

Address Kensington, Md. Date signed 4/5/46

RECEIVED
APR 10 1946
BUREAU OF AERONAUTICS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Beltsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs.Hospital, institution, or street address where death occurred:
116 Maple Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Beltsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 116 Maple Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Marshall Edmond Briscoe Marshall Edmond

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Edith M. Briscoe1925-1975 8.(c) If alive, give age 41 years7. Birth date of deceased (mo., day, yr.) Jan-25-18758. AGE: Years 71 Months 2 Days 11 less than one day
hrs. min.9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation carpenter

11. Industry or business

12. Name Philip E. Briscoe13. Birthplace Maryland14. Maiden name Leila Ann Humphreys15. Birthplace Fredricksburg, Va.16. Informant Edith M. BriscoeAddress 116 Maple Ave Beltsville17. Burial Date thereof April 8-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington D.C.18. Funeral director Arthur J. WaltersAddress 254 Avenue H Beltsville19. April 8 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 1946 at 9:1 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 29 1946 to April 5 1946
and that I last saw him alive on April 4 1946Immediate cause of death Carcinoma of left lung
(Probably bronchio-
genic adeno-
carcinoma)

DURATION

5 mo.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles T. Carroll M.D.

Charles T. Carroll, M.D.

M. D. or other

Address 6801 6th St. N.W. Wash. D.C. Date signed 4/5/46

RECEIVED
APR 8 1946
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BPa)

CERTIFICATE OF DEATH

03887

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery
City or town Germantown MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Fifty Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Germantown MD. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(e) IF VETERAN, NAME WAR

None

3. (a) FULL NAME

John Wesley. Chambers

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

Rosetta Chambers

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

May 10 1868

8. AGE:

Years

Months

Days

If less than one day

77

10

26

hrs.

min.

9. Birthplace

Fairfax VA.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Farm

FATHER

12. Name

Daniel Chambers

MOTHER

13. Birthplace

VA.

14. Maiden name

Fannie Unknown

15. Birthplace

Unknown

16. Informant

Mary Prather

Address

Germantown MD.

17.

Burial

Date thereof

April 8 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Brook grove MD.

Location

Laytonsville MD.

18. Funeral director

Roy W. Barber

Address

Laytonsville MD.

19.

April 8 1946
Date rec'd by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 5

1946 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 March

19

46

to

April 5

19

46

and that I last saw him alive on

April 7

19

46

Immediate cause of death

Chronic nephritis with edema

DURATION

7 yrs.

Due to

Arteriosclerosis

20 yrs.

Due to

Other conditions

Smility

(Include pregnancy within 3 months of death)

Major findings:

Df operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.D. D. D.

M. D. or other

Address

Dawsonville, Md.

Date signed

8 Apr 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 13 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County MontgomeryCity or town Poolesville, Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Barnesville, Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Elizabeth Cole

3. (b) Social Security Number

4. W 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife John E. Cole7. Birth date of deceased (mo., day, yr.) Nov 7 1886 6. (c) If alive, give age _____ years8. AGE: Years 59 Months 5 Days 7 If less than one day _____ hrs. _____ min.9. Birthplace Farmers Co. Md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Frank Nichols13. Birthplace Md.14. Maiden name Unknown

15. Birthplace

16. Informant Thomas ColeAddress Boyd, Md.17. (Burial, cremation, or removal, Which?) Buried Date thereof 4/16/46
(month) (day) (year)Cemetery or crematory MonocacyLocation Barnesville, Md18. Funeral director William B. HiltonAddress Barnesville, Md.19. April 16 46 (Date rec'd by registrar) Registrar Charles J. Elgin

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 - 1946 at 5:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 - 1945 to April 14 - 1946 and that I last saw him alive on April 13 - 1946Immediate cause of death Carcinoma of liver

DURATION

2 yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Byron D. White, M.D.

M. D. or other

Address Poolesville, Md. Date signed 4/15/46

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

APR 20 1946
BUREAU 7 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1670

CERTIFICATE OF DEATH

03889

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Westmoreland Hills
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 65 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Westmoreland Hills
(If outside city or town limits, write RURAL and give nearest town)Street No. Duval Drive
(If rural, give LOCATION)2.(a) If veteran, name war No

3. (a) FULL NAME

James Edward Collins

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lucile Esther Seaton Collins6. (c) If alive, give age 44 years7. Birth date of deceased (mo., day, yr.) July 8, 1880

8. AGE: Years Months Days If less than one day

65826

hrs.

min.

9. Birthplace Montgomery County, Maryland
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farming12. Name Joseph J. Collins13. Birthplace Maryland14. Maiden name Sally Dean15. Birthplace Maryland16. Informant Mrs. Lucile Esther Seaton CollinsAddress Duval Dr., Westmoreland Hills, Md.17. Burial Date thereof April 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Zion Church CemeteryLocation Bethesda, Maryland18. Funeral director Wm. Larkin HumphreyAddress Bethesda, Maryland19. 4/6 19 46 Thos E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 6 19 46 at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sup. Med. Exam Case 19 46 to 19 46and that I last saw h. alive on 19 46

Immediate cause of death

AsphyxiaDue to hanging (suicide)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. suicide Date of 4-4-46Where did injury occur? Westmoreland Hills (City or town) MD (County) MD (State)Injured at home, farm, industry, public place (where?) Home

Means of injury Injured at work?

23. SIGNATURE Frank J. Brochant M.D.Address Sup. Med. Exam M. D. or otherDate signed 4-4-46

DURATION

Found hanging in back crib.

RECEIVED

APR 12 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 hrs
 Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution? 22 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist of Col. County Washington
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4400 Kashiwa Ave NW
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war.....

3. (a) FULL NAME

JOSEPH FRANCIS COOKE

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife..... 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) Feb 21 1931
 8. AGE: Years 15 Months 1 Days 9 It less than one day..... hrs. min.

8. Birthplace Scranton Pa
 (Town, county, and state)
 10. Usual occupation Student
 11. Industry or business.....
 FATHER 12. Name John Cooke
 13. Birthplace Scranton Pa
 MOTHER 14. Maiden name Stella Smith
 15. Birthplace Scranton Pa

16. Informant mother
 Address 4400 Kashiwa Ave NW
 17. Removal Date thereof Apr 4, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....
 Location Scranton Pa
 18. Funeral director W W Chambers Co
 Address 1400 Chapin St NW
4-2-46 W E Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1946 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31, 1946 to April 2, 1946
 and that I last saw him alive on April 2, 1946 at 1946

Immediate cause of death Pulmonary edema DURATION

Due to.....

Due to.....

Other conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE William Jones M. D. or otherAddress 546 Maple Ridge Rd Date signed 4-2-46
Bethesda Md.

RECEIVED

APR 4 1946

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03891

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N.C. County _____
City or town Burlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

CRAVEN, Clyde Charles

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 19 March 1900

8. AGE: Years 46 Months 0 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual occupation UNKNOWN

11. Industry or business _____

12. Name James Craven

13. Birthplace N.C.

14. Maiden name unknown

15. Birthplace unknown (dec)

16. Informant father: Mr. James Craven

Address Burlington, N. C.

17. burial Date thereof 4-6-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. Chambers

Address 1400 Chapin St., N. W., Wash., D.C.

19. 4-4 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 4 1946, at 9:28 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 March 1946 to 4 April 1946

and that I last saw him alive on 4 April 1946

Immediate cause of death _____

Pneumonia
Edema Brain

Due to Bronchopneumonia, confluent.

Due to Duration: 3 days. P.S.R.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE C. H. C. Smith Comdr. (MC) USNR

Address USNH Bethesda, Md. Date signed 4-4-46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4/2/46

RECEIVED
APR 20 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age of deceased is shown **MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore (942)

FILM No. I 04 JUN - 4 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 03892 223

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred:
18 Elm Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 18 Elm St.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Guy Hamilton Crooker

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Emeline Marion Crooker

7. Birth date of deceased (mo., day, yr.) Jan 23 1871

8. AGE: Years 74 Months 4 Days 13 If less than one day hrs. min.

9. Birthplace Lewis County West Virginia
(Town, county, and state)

10. Usual occupation Retired Clergyman

11. Industry or business

12. Name George Washington Crooker

13. Birthplace W. Va.

14. Maiden name Marian Spears

15. Birthplace

16. Informant Emily Marion Crooker

Address 18 Elm Ave. - Takoma Park, Md.

17. Burial Date thereof April 13 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Clarksville Cemetery

Location Clarksville, W. Va.

18. Funeral director Wm B. Wilton

Address Barnesville, Md.

19. April 10 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Defunct. Exam case 19... to 19... and that I last saw him alive on 19... Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brochant M.D.

Address Clarksville, Md. Date signed 4-10-46

RECEIVED
APR 12 1946
RITZ AU V & S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 78-0

CERTIFICATE OF DEATH

Reg. Dist. No. 138273

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 11 Philadelphia Ave.
Stay in hospital or inst. (yrs., or mos., or days) 24th Nov 1945
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____
City or town Washington D.C. Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 4112 5th St. N.W.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Victoria E. Curtis

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John W. Curtis

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 7 1864

8. AGE: Years 82 Months 0 Days 8 hrs. _____ min. _____

9. Birthplace Culpepper County Virginia
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name James William Brown

13. Birthplace Culpepper County Virginia

14. Maiden name Mary C. Dempsey

15. Birthplace Culpepper County Virginia

16. Informant Edward R. Curtis

Address 4112 5th St. N.W. Wash. D.C.

17. Removal Date thereof 4/15/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Washington D.C.

18. Funeral director Huntmanns Funeral Home

Address 5732 Georgia Ave. N.W. Washington

19. April 11 1946 Registrar William A. Smith
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1946 10:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25, 1946 to Apr. 15, 1946, and that I last saw him alive on Apr. 14, 1946.

Immediate cause of death

Congestive heart failure
Due to arterio-sclerosis
Due to _____
Other conditions _____

DURATION

4 days
relapsing

(Include pregnancy within 8 months of death)

Major findings:

Of operations _____

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE

William A. Smith M. D. or other
Address 6911 5th St. N.W. Date signed 4/15/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 17 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Cherry Chase
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 hrs

Hospital, institution, or street address where death occurred:

6401 Burkwood Dr.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 2713 Ordway St

(If rural, give LOCATION)

2.(a) If veteran, name war (Resident of IRAN) ✓

3. (a) FULL NAME

Ali Akbar Daftary

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Zahra

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

4471901

hrs.

min.

9. Birthplace Teheran

(Town, county, and state)

10. Usual occupation Diplomat

11. Industry or business

MOTHER FATHER

12. Name Mahmond D.13. Birthplace Teheran14. Maiden name Behzadi15. Birthplace Teheran16. Informant Iran EmbassyAddress 3003 Mass. Ave., N.W., Wash., D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 4/26/46

(month) (day) (year)

Cemetery or crematory Cedar Hill CemeteryLocation Maryland18. Funeral director W. Reuben HumphreyAddress Bethesda, Maryland19. 4/25 19 46
(Date rec'd by registrar)Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 21 19 46 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept med Exam 19 46 to 19 46and that I last saw him alive on Exam case 19 46

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Bronchart M.D. M. D. or otherAddress Washington, D.C. Date signed 4-21-46

03894

RECEIVED
APR 29 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Dead upon arrival 2 PM

Hospital, institution, or street address where death occurred:

Suburban Hospital - 8600 Old Georgetown Rd.How long in hospital or institution? Dead upon arrival 2 PM

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D.C. County D.C.City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 4914 Belt Rd. N.W.
(If rural, give LOCATION)

12. (a) If veteran, name war

3. (a) FULL NAME

Baby DAY (boy)4. Sex m 5. Color or race White 6. (a) Single, married, widowed, or divorced Premature (5 mos)6. (b) Name of husband or wife Baby6. (c) If alive, give age 5 mos years7. Birth date of deceased (mo., day, yr.) 4-12-468. AGE: Years 2 Months 2 Days 2 If less than one day 2 hrs. 2 min.9. Birthplace 4914 Belt Rd. - Washington D.C.
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

12. Name Merril Day13. Birthplace Ohio14. Maiden name Winifred Moxley15. Birthplace Washington D.C.16. Informant WINFRED M. DAYAddress 4914 Belt Rd. Washington D.C.17. Cremation Date thereof April 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Suburban Hospital Bethesda MDLocation Suburban Hospital Bethesda MD18. Funeral director A.B. Jones, Inc.Address 8600 Old Georgetown Rd Bethesda, MD19. 4/16 19 46 Wm E Jones
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12 19 46 at 2:15 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-12 19 46 to 4-12 19 46 and that I last saw him alive on 4-12 19 46Immediate cause of death Prematurity - 5 months DURATIONSurvived 2 hours.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P.P. Andrews M.D. M. D. or otherAddress 4201 Kensington St N.W. Date signed 4-12-46Common notified & O.K.

RECEIVED
APR 20 1946
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

03896

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 days 16 hours
 Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution? 8 days 16 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9500 Georgia Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No.

3. (a) FULL NAME

FREDERICK M. DICKINSON

3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Babette
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Jan. 8th. 1877
 8. AGE: Years 69 Months 3 Days 14 If less than one day hrs. min.
 9. Birthplace Snell, Virginia
 (Town, county, and state)
 10. Usual occupation Real Estate Broker
 11. Industry or business
 12. Name Richard Dickinson
 13. Birthplace Snell, Virginia
 14. Maiden name Mary Crutchfield
 15. Birthplace Snell, Virginia

16. Informant Mrs. Babette Dickinson
 Address 9500 Ga. Ave. Silver Spring.
 17. Burial Date thereof 4-24-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Fort Lincoln
 Location Prince Georges Co. Md.
 18. Funeral director James E. Humphrey
 Address 8434 Ga. Ave. Silver Spring, Md.
 19. 4/26 1946 Wm E Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22nd 1946 at 12 noon
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10th 1946 to April 22 1946
 and that I last saw him alive on April 22, 1946
 Immediate cause of death Coronary thrombosis DURATION 12 days
 Due to
 Due to
 Other conditions pulmonary embolism
3. lateral thrombo-phlebitis
 (Include pregnancy within 3 months of death)
 Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Marion Bonhead M.D. M. D. or other
9601 Sutton Place
 Address Silver Spring Date signed 4/22/46

RECEIVED

APR 29 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460

CERTIFICATE OF DEATH

03897

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 79 Days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.How long in hospital or institution? 79 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 725 6th St. NE Washington, D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Charles Theodore DORSEY V.B.P.

3.(b) Social Security Number

4. Sex male 5. Color or race negro 6.(a) Single, married, widowed, or divorced single

8.(b) Name of husband or wife

5.(c) If alive, give age years7. Birth date of deceased (mo., day, yr.) April 23 19058. AGE: Years 41 Months 0 Days 4 If less than one day hrs. min.9. Birthplace Washington, D.C.
(Town, county, and state)10. Usual occupation Porter11. Industry or business 5+10 store12. Name Edmond Dorsey (dec)13. Birthplace Wash., D.C.14. Maiden name Janne Sims15. Birthplace Wash., D.C.16. Informant Mrs. Jannie (Sims) DorseyAddress 725 6th St. NE Wash., D.C.17. burial Date thereof 4-30-46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematorium Arlington NationalLocation Arlington, Va.18. Funeral director Alexander S. Pope A.S. PopeAddress 315 15th St. S.E. Wash., D.C.19. 27 April 46
(Date rec'd by registrar)Mary Charlotte Smith
Registar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 19 46 at 2:40 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Feb. 19 46 to 27 April 19 46and that I last saw him alive on 27 April 19 46

Immediate cause of death

DURATION

Carcinoma of Esophagus 6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma of Esophagus

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

SIGNATURE Frank S. Ashburn, Comdr. (MC) USNMary Charlotte Smith M. D. or other 4-27-46Address Bethesda, Md. Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1946

BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

Suburban Hospital
How long in hospital or institution? 45 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. F. D. # 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Arthur Dove

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male colored married

6.(b) Name of husband or wife Margaret

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1917.

8. AGE: Years Months Days If less than one day
28 5 23 hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

12. Name Arthur Dove

13. Birthplace Ind.

14. Maiden name Louise ?

15. Birthplace Ind.

16. Informant

Address

17. Burial Date thereof 4-14-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Scotland Cemetery

Location Scottdale, Ind.

18. Funeral director R. L. Szwedzen

Address Rockville, Ind.

19. 4/14 46 John E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1946 at 7:40 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25, 1946 to April 11, 1946 and that I last saw him alive on April 11, 1946

Immediate cause of death

Uremic metastatic carcinoma

Due to carcinoma of rectum

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Extension of carcinoma into

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Nowakowski M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly.

RECEIVED
APR 20 1946
BUREAU V. A.

Evidence for change of
date of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 197-2

03899

CERTIFICATE OF DEATH

Reg. Dist. No. 216

FILM No. I O 4 MAY 15 1946

1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Days

Hospital, institution, or street address where death occurred:

U. S. Naval Bethesda, Md.

How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...

City or town... Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1133 6th St. NW Washington, D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3.(a) FULL NAME

Alfred (n) DURBIN V.B.P.

3.(b) Social Security Number

4. Sex male 5. Color or race negro 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife... Mrs. Irene Durbin

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Feb 29 1918

8. AGE: Years 29 Months 58 Days 27 If less than one day... hrs. ... min.

9. Birthplace... Maryland
(Town, county, and state)

10. Usual occupation... Disabled Veteran

11. Industry or business

12. Name... unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Mrs. Irene Durbin

Address 1133 6th St. NW Washington, D.C.

17. burial Date thereof 4-30-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Arlington National

Location Arlington, Va.

18. Funeral director... Ernest W. Jarvis

Address 1423 U St. NW Washington, D.C.

19. 26 April 19 46 Mary C. Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 26 April 19 46 at 9:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 April 19 46 to 26 April 19 46

and that I last saw him alive on 26 April 19 46

Immediate cause of death... Uremia

DURATION 10 days

Due to Enlargement Prostate gland

Due to Pylonephritis

Other conditions 10 days

(Include pregnancy within 3 months of death)

Major findings of operations... (ascending)

Autopsy results Prostatic hypertrophy & renal infarct

PHYSICIAN: Please underline the cause to which death should be charged statistically. of

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of 8. v. 1946

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Choking Injured at work?

23. SIGNATURE... C. W. THOMPSON, Lt. Comdr. (MC) USNR

Address... USNH Bethesda, Md.

Date signed 4-26-46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4/30/46

RECEIVED
MAY 8 1946
BUREAU V L

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

Reg. Dist. No. 03900213.

1. PLACE OF DEATH:

County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

505 Charles St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. 505 Charles St.

(If rural, give LOCATION)

2.(a) If veteran, name war ★ World War I

3. (a) FULL NAME

Millard J. Engle

3. (b) Social Security Number

579-16-5222

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Zenora Engle6.(c) If alive, give age 52 years7. Birth date of deceased (mo., day, yr.) March 16, 1890

8. AGE: Years Months Days It less than one day

56 1 5 hrs. min.9. Birthplace Frederick Co. Md.

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name John M. Engle13. Birthplace West VirginiaMOTHER 14. Maiden name Anna Catherine Wilson15. Birthplace West Virginia16. Informant Betty J. BarrettAddress 505 Charles St. Rockville, Md.17. Burial Date thereof 4/24/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet CemeteryLocation Frederick, Maryland18. Funeral director Wm Reuben HumphreyAddress Rockville, Maryland19. 4/23/46 Josephine D. Wallon

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 21 1946 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sig med Exam to 19and that I last saw h... alive on same case 18

Immediate cause of death

Acute cardiac dilatation

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Frank J. Bruchant M.D.23. SIGNATURE Sig med Exam M. D. or otherAddress Yakeshburg Md Date signed 4-21-46

RECEIVED
APR 25 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of **MARYLAND STATE DEPARTMENT OF HEALTH**
name of county & town where death occurred is shown on 2411 N. Charles St., Baltimore 742

03901

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: MAY - 1 1946
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....Md..... County.....
City or town.....Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.....102 Quincy Street
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME

Rosanna Fix

3.(b) Social Security Number

4. Sex female **5. Color or race** white **6.(a) Single, married, widowed, or divorced** Married
6.(b) Name of husband or wife Clifford
7. Birth date of deceased (mo., day, yr.) September 8, 1906
8. AGE: Years 39 Months Days If less than one day
.....hrs.min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER **12. Name** Robert McClean
13. Birthplace Pennsylvania
MOTHER **14. Maiden name** Mary--
15. Birthplace Pennsylvania

16. Informant Clifford E. Fix
Address 102 Quincy St., C.C., Md.

17. Burial Date thereof April 22, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory XX Flohrs Cemetery
Location Gettsburg, Pennsylvania

18. Funeral director The S. H. Hines Company
Address 2901 14th St., N.W. Wash, D.C.

19. 4/20/46 9pm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1946 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to April 1946 and that I last saw her alive on April 19, 1946.

Immediate cause of death Acute myelogenous leukemia

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul D. Cantow MD
M. D. or other

Address 7425 Wisconsin Date signed 4/20/46

CERTIFICATE OF DEATH

RECEIVED
APR 27 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

CERTIFICATE OF DEATH

03902

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Mongomery
City or town Bethesda, Md. (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Days
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 7 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State _____ County _____
City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111 11th St., S.E.
(If rural, give LOCATION) ✓
2.(a) If veteran, name war _____

3. (a) FULL NAME

John Francis FLAHERTY, V.B.P.

3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept 1860

8. AGE: Years 85 Months 8 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual occupation Veteran

11. Industry or business _____

12. Name James Flaherty (dec)

13. Birthplace Ireland

14. Maiden name Catherine Sullivan (dec)

15. Birthplace Ireland

16. Informant Mary C. Krahling

Address 111 11th St. S.E. Washington, D.C.

17. burial Date thereof 4-29-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Washington, D.C.

18. Funeral director James T. Ryan Inc.

Address 317 Penna. Ave. Washington, D.C.

19. 26 April 19 46 Mary Charlotte Smith
(Date rec'd by registrar) (Signature)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 April 19 46 at 8:15 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 April 19 46 to 26 April 19 46

and that I last saw h. im alive on 26 April 19 46

Immediate cause of death _____ DURATION _____

Arteriosclerosis ? years
Due to cerebral

Arteriosclerosis ? years
Due to generalized

Broncho pneumonia 4 days
Due to Bulbar paralysis 10 days
(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results sent. int. sub. J. Brondino Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury CW Thompson Injured at work? _____

Signature C. W. THOMPSON, Lt. Comdr. (MC) USNR
M. D. or other _____

Address USNH Bethesda, Md.

Date signed 4-26-46

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4/30/46

RECEIVED

MAY 3 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

03903

Reg. Dist. No. 2/3

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Alkanal Fletcher

3. (b) Social Security Number

4. Sex

male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Mary Fletcher

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age _____ years

1885

8. AGE:

Years

Months

Days

If less than one day

61

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Janitor

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial
(Burial, cremation, or removal, which?)Date thereof 4-10-46
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-5-46 19____ at 11:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 4:20 AM, 1946 to 4-5-46 1946
and that I last saw him alive on 4-5-46 at 11:30 AM, 1946

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Ruptured gastric ulcer and
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address _____ Date signed _____

Peritonitis

RECEIVED

APR 12 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03904

Reg. Dist. No. 216

1. PLACE OF DEATH

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2-51 Mins.
 Hospital, institution, or street address where death occurred:
Suburban Hospital, Georgetown Rd.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Gaithersburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Route #3
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Infant (girl) Frazier

3. (b) Social Security Number

4. Sex

Female

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

Infant -

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 24, 1946 @ 6:19 PM
 6. (c) If alive, give age 2 hrs. 51 mins.
 8. AGE: Years Months Days If less than one day
2 hrs. 51 min.

9. Birthplace Bethesda, Montgomery, Maryland
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

46

J. M. E. L. L. L.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1946 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 24 6:19 PM to 9:10 PM April 24
 and that I last saw him alive on April 24 19 46
 Immediate cause of death Asphyxia

Due to Mechanical blockage of trachea
 Due to Aspiration of mucus and meconium
 Other conditions

DURATION

2 hrs.
51 minutes

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results Tracheal obstruction - Caudex hypertrophy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE

Berbaire Macellito MD

M. D. or other

Address

Date signed

RECEIVED

MAY 3 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2411)

CERTIFICATE OF DEATH

03905

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Days
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D.C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 220 9th St. N.E.
(If rural, give LOCATION) ✓
2. (a) If veteran, name war _____

3. (a) FULL NAME

James Albert GRANT, CMM USN Ret. Active

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Mrs. Marie Grant
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) May 11, 1885
8. AGE: Years 60 Months 11 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Tenn.
(Town, county, and state)
10. Usual occupation U.S. Navy
11. Industry or business _____
12. Name Henry Grant
13. Birthplace Tenn.
14. Maiden name Rebecca Yalsey Johnson
15. Birthplace Tenn.

16. Informant Mrs. Marie Grant
Address 220 9th St. N. E. Wash., D.C.
17. burial Date thereof 5-3-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington, Virginia
18. Funeral director Geo. W. Wise
Address 2900 M Street, N. W., Wash., D.C.
19. 30 Apr. 1946 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 April 19 46 at 0221 a
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 April 19 46 to 30 April 19 46
and that I last saw him alive on 30 April 19 46
Immediate cause of death Cirrhosis, liver, atrophic
DURATION _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings of operations _____
Autopsy results Cirrhosis, liver, atrophic, subacute
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE J. B. Shuler
J. B. SHULER, Comdr. (MC) USN
M. D. or other _____
Address USNH Bethesda, Md. Date signed 4-30-46

RECEIVED

MAY 3 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

03906

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
 City or town Olney, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Gaithersburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Woodyield
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elmer W. Green

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mrs. Mary Green
 6.(c) If alive, give age 47 years
 7. Birth date of deceased (mo., day, yr.) February 12, 1896
 8. AGE: Years 50 Months 2 Days 10 If less than one day
hrs.min.

9. Birthplace Woodyield, Montg. Co., Maryland
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Joseph L. Green
 13. Birthplace Germany
 14. Maiden name Catherine Weber
 15. Birthplace hagtersville, Maryland
 16. Informant Hospital record

17. Burial Date thereof 4/12/1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Wesley Grove
 Location Woodfield Md.
B. Beall Inc.

18. Funeral director Adamasus Md.
 Address

19. 4-24- 46 Ge. Webb, Lawbr
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1946 at 9 ⁴⁵ P. ⁴⁵ M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 1946, to April 22 1946
 and that I last saw him alive on April 22 1946

Immediate cause of death Acute cardiac
dilatation

DURATION

1 day

Due to Cronis myocarditis months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Broz M. D. or other

Address Sandy Spring, Md. Date signed 4/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 16 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

03547

216

Reg. Dist. No.

1. PLACE OF DEATH:

County.....Montgomery
City or town.....Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....1 month, 5 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution?.....1 month, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....N.Y. County.....
City or town.....Syracuse
(If outside city or town limits, write RURAL and give nearest town)
Street No.....261 Roosevelt Avenue
(If rural, give LOCATION) ✓
2.(a) If veteran, name war.....

3. (a) FULL NAME

GRIDLEY, Carlton Willis

3. (b) Social Security Number

4. Sex.....male
5. Color or race.....W-US
6.(a) Single, married, widowed, or divorced.....single

8.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....Nov. 6, 1919

8. AGE: Years.....26 Months.....5 Days.....29
If less than one day..... hrs. min.

9. Birthplace.....N.Y.
(Town, county, and state)

10. Usual occupation.....Clerk typist

11. Industry or business.....Navy Dept.

12. Name.....James Gridley

13. Birthplace.....N.Y. (dec)

14. Maiden name.....Algerose Chapel

15. Birthplace.....N.Y.

16. Informant.....Mother: Mrs. Algerose Chapel Gridley

Address.....261 Roosevelt Avenue, Syracuse, N.Y.

17.....burial Date thereof.....
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Hillside

Location.....Central Square, N.Y.

18. Funeral director.....W. W. CHAMBERS-613

Address.....1400 Chapin St. N.W., Wash., D.C.

19.....4-5.....46.....Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....5 April.....46.....2:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1 March.....46.....to.....5 April.....46

and that I last saw h.....im.....alive on.....19.....

Immediate cause of death.....Leukemia, Acute
Myeloid

DURATION
8 wks

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

.....J. B. Shuler.....

.....J. B. Shuler, Comdr. (MC) USN.....

23. SIGNATURE.....

Address.....USNH Bethesda, Md......

.....Date signed.....4-5-46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4/10/46

RECEIVED

APR 12 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03907

Reg. Dist. No.

223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 mo. 23 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
 How long in hospital or institution? 8 mo. 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Galithersburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. —
 (If rural, give LOCATION)
 2.(a) If veteran, name war —

3.(a) FULL NAME

Mrs. Grace Griffith

3.(b) Social Security Number

4. Sex Female 5. Color or race Cauc. 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Clarence Griffith
 (deceased) 6.(c) If alive, give age — years
 7. Birth date of deceased (mo., day, yr.) January 5, 1870
 8. AGE: Years 76 Months 3 Days 3 If less than one day — hrs. — min.

9. Birthplace Fredrick md.
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business —

MOTHER FATHER 12. Name Lysander E. Hobson

13. Birthplace Fredrick Co. md.

14. Maiden name Anna Price

15. Birthplace Fredrick Co. md.

16. Informant Marie Carey (sister)

Address Ocean City md.

Records Washingt. Sen. Hosp.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 4/18/46
 (month) (day) (year)

Cemetery or crematory Grand Oak Cemetery

Location Galithersburg md.

18. Funeral director E. L. Galtner

Address Galithersburg md.

19. (Date rec'd by Registrar) April 9 46 Registrar —

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8 1946 at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1945 to 4/8 1946.

and that I last saw her alive on 4/5 1946.

Immediate cause of death Arterial Fibrillation and
terminal cardiac dilatation DURATION 1 da.

Due to Cachexia

Due to Primary Carcinoma of Stomach Spring 1945

Other conditions Cardiovascular disease

(Include pregnancy within 3 months of death)

Major findings of operations Inoperable Carcinoma of
Stomach - Liver extension Date of op. July 30, 1945

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE J. L. Kotz md. M. D. or other —

Address Takoma Park md. Date signed 4/8/46

RECEIVED
APR 12 1946
BUREAU OF
POSTAL SERVICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

03908

Reg. Dist. No. 223

1. PLACE OF DEATH: MONTGOMERY
 County Montgomery
 City or town Normal Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 YEARS.
 Hospital, institution, or street address where death occurred:
10 PINE AVE.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State MD. County MONTG.
 City or town TAKOMA PARK
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 10 PINE AVE.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME ELLA F. GROUT

3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced WIDOWED.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 27, 1860

8. AGE: Years 85 Months 3 Days 10 It less than one day
 hrs. min.

9. Birthplace SCREEN LAKE, N.Y.
 (Town, county, and state)

10. Usual occupation AT HOME

11. Industry or business OWN HOME

12. Name EDWARD MAGDON

13. Birthplace CANADA.

14. Maiden name HOLDAH BRUCE

15. Birthplace NY

16. Informant EDITH G. VAYO.

Address 10 PINE AVE., TAKOMA PARK, N.Y.

17. CREMATION Date thereof APRIL 8, 1946.
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CEDAR HILL CREMATORY

Location PENNA AVE SE. EXTENDED

18. Funeral director Arthur J. Talbot

Address 254 Barratt St. N.E., Takoma Park D.C.

19. Apr. 6 19 46

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 April 19 46, at 9⁰⁰ P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1 19 46, to Apr. 6 19 46.
 and that I last saw her alive on Apr. 6, 2 p.m. 19 46

Immediate cause of death Respiratory Failure DURATION 12 hrs.

Due to Cerebral Haemorrhage 7 days.

Due to Hypertensive Heart Disease and arteriosclerosis 10 years.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. B. Queen M.D. M. D. or other

Address Takoma Park, Md. Date signed Apr. 6, 1946

RECEIVED
APR 9 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8-0

CERTIFICATE OF DEATH

03909

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 935 Boulevard St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Charles Hewelrow

3. (b) Social Security Number

4. Sex male 5. Color or race col 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Luigia Hewelrow 6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) April 12 1905

8. AGE: Years 40 Months 11 Days 20 If less than one day hrs. min.

9. Birthplace Melford Pa
(Town, county, and state)

10. Usual occupation Janitor

11. Industry or business

12. Name Ed. Hewelrow

13. Birthplace Pa

14. Maiden name Paga Galloway

15. Birthplace Pa

16. Informant Jef. Coleman

Address 1134 Adam St N.W. D.C.

17. Burial Date thereof Apr. 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Fredericksburg, Va

18. Funeral director Francis Funeral & Serv. Inc

Address 389 R. I. Ave NW Wash DC

19. Apr. 2 19 46 Josephine M Schagge
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 19 46 at 8:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Cerebral hemorrhage DURATION 4 1/2 hrs

Due to

Due to

Other conditions Hypertension 2 yrs

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Broschaut M.D. M. D. or other

Address Washington DC Date signed Apr 2 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 5 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

03910

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 810 Burlington Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Daniel George Hourihane

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 1877

8. AGE: Years Months Days If less than one day
68 hrs. min.

9. Birthplace Leesburg Va
(Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business

12. Name Michael Hourihane

13. Birthplace Ireland

14. Maiden name Joanna Burke

15. Birthplace Ireland

16. Informant Mrs Mammie Sullivan

Address Leesburg Va

17. Burial Date thereof April 9-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Leesburg Va

18. Funeral director Warner E. Rumphrey Inc.

Address 8434 Geo Ave Silver Spring Md.

19. April 7 1946 Josephine M. Schaefer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/7/46 at 4:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 1942 to Apr 7 1946

and that I last saw him alive on Apr 16 1946

Immediate cause of death

Metastatic carcinoma, bronchial

Due to Bronchitis; duration 5 days

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard Thomas M. D. or other

Carollee Takem Date signed 4/7/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

RECEIVED
APR 10 1946
BUREAU OF VITALS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74

CERTIFICATE OF DEATH

03911

Reg. Diat. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

10,525 Sweetbrier Parkway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomerySTREET 10,525 Sweetbrier Parkway
City or town (If outside city or town limits, write RURAL and give nearest town)CITY Silver Spring, Md.
Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Albert C. Hunter

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

B.(b) Name of husband or wife

Elizabeth H. Hunter

7. Birth date of

deceased (mo., day, yr.) Feb. 23, 1893

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

53120

hrs.

min.

9. Birthplace

East Providence, R.I.
(Town, county, and state)

10. Usual occupation

Bacteriologist

11. Industry or business

FATHER

12. Name

George F. Hunter

13. Birthplace

East Providence, R.I.

MOTHER

14. Maiden name

Susan F. Salisbury

15. Birthplace

East Providence, R.I.

16. Informant

Mrs. Elizabeth H. Hunter

Address

10,525 Sweetbrier Parkway17. Shipment & burial

(Burial, cremation, or removal. Which?)

Date thereof

April 6, 1946
(month) (day) (year)

Cemetery or crematory

Lakeside Cemetery

Location

East Providence, Providence Co., R.I.

18. Funeral director

Warner E. Pumphrey

Address

Silver Spring, Md.19. April 15, 1946

(Date rec'd by registrar)

Josephine M. Schaeffer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1946 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Self med. Exam case 19... to 19...
and that I last saw him alive on 19...

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Brorhaug M.D.
Self med. Exam M. D. or other
Address Washington, Md. Date signed 4-24-46

1946

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 18 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (642)

CERTIFICATE OF DEATH

03912

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

6912 Apr Lane

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 6912 Apr Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Virginia C Hutton

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Alvin Hutton7. Birth date of deceased (mo., day, yr.) Nov 28 1908 6.(c) If alive, give age 42 years8. AGE: Years 37 Months 4 Days 16 If less than one day
hrs. min.9. Birthplace Wash. D.C.
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Samuel H. Simmons13. Birthplace Wash. D.C.14. Maiden name See May Cyrus15. Birthplace Wash. D.C.18. Informant Alvin HuttonAddress 6912 Apr Lane Bethesda Md17. (Burial, cremation, or removal. Which?) Date thereof 4-3-1946
(month) (day) (year)

Cemetery or crematory

Location Washington D.C.18. Funeral director Joe Hawley SonsAddress 11756 Penn ave. Wash, D.C.19. 4/3 46 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 3 1946, at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Self and team care 19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Apoplexy
Due to hypertension (suicide)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 4-3-46Where did injury occur? Bethesda Montg Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) home

Means of injury Injured at work?

23. SIGNATURE Frank J. Brochant M.D. M. D. or otherAddress Bethesda Md Date signed 4-3-46

DURATION

Found dead in home

RECEIVED

APR 12 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03913

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... MontgomeryCity or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 42 Days

Hospital, institution, or street address where death occurred:

Naval Hospital, Bethesda, Md.How long in hospital or institution?..... 42 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....City or town..... Woodmore
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

James (n) JACKSON V. B. P.

3.(b) Social Security Number

4. Sex..... male
5. Color or race..... negro
6.(a) Single, married, widowed, or divorced..... single

6.(b) Name of husband or wife.....

8.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... Apr 14 18928. AGE: Years..... 54 Months..... 0 Days..... 7
If less than one day..... hrs. min.9. Birthplace..... Maryland
(Town, county, and state)10. Usual occupation..... General Laborer

11. Industry or business

12. Name..... George W. Jackson (dec)13. Birthplace..... Md.14. Maiden name..... Sara Jessup (dec)15. Birthplace..... Md.16. Informant..... Mr. Joe JacksonAddress..... 88 Finley St. NE Wash., D.C.17. burial Date thereof..... 4-24-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... WoodmoreLocation..... Woodmore, Md.18. Funeral director..... W.E. JarvisAddress..... 1432 U Street, N.W., Washington, D.C.19. 21 April 19 46
(Date rec'd by Registrar)Mary Charlotte Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 20 19 46, at 0712a M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
8 March 19 46 to 20 April 19 46and that I last saw h..... im alive on..... 19.....

Immediate cause of death.....

UREMIA

DURATION

Due to..... RENAL DISEASE OF UNKNOWNETIOLOGY

Due to.....

Other conditions..... Carcinoma BladderSyphilis

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Gun Cannon Injured at work?23. SIGNATURE..... E. M. CANNON, Lt. (MC) USNR
M. D. or otherAddress..... USNH Bethesda, Md. Date signed..... 4-21-46

RECEIVED

MAY 3 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03914

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Chevy Chase 6304 Oak Ridge Ave.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
None
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County Yates
City or town Penn Yan
(If outside city or town limits, write RURAL and give nearest town)
Street No. 254 E. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME

Miss Jensen Jensen

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife John V. Jensen

6. (c) If alive, give age. Deceased years

7. Birth date of deceased (mo., day, yr.) April 26, 1871

8. AGE:

Years

Months

Days

If less than one day

74

11

6

hrs.

min.

9. Birthplace Denmark

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name (Unknown) Jensen

13. Birthplace Denmark

14. Maiden name Margaret (Unknown)

15. Birthplace Denmark

16. Informant Mrs. Richard L. Hanson

6304 Oak Ridge Ave.

Address Chevy Chase, Md.

17. burial Date thereof April 5, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Lakeside Cemetery

Location Penn Yan, N. Y.

18. Funeral director Wm. Hansen Pumphrey

Address Bethesda, Maryland

19. 4/3 19 46

(Date rec'd by registrar)

Wm. E. Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1946 at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med. Exam 19 19 to 19 19

and that I last saw him alive on 19 19

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brownhart M.D. M. D. or other

Address Washington Md Date signed 4-2-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 12 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03915

Reg. Dist. No.

223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 47 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 47 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. of Col. County City or town Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2.(a) If veteran, name war

3.(a) FULL NAME

Jones Mrs. John Bernard

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Mrs. Eva S. Jones6.(c) If alive, give age years7. Birth date of deceased (mo., day, yr.) May 24, 18998. AGE: Years 67 Months 11 Days If less than one day hrs. min.9. Birthplace Takoma Park, Md.
(Town, county, and state)10. Usual occupation Retired Decorator11. Industry or business

MOTHER FATHER

12. Name Information not available13. Birthplace 14. Maiden name 15. Birthplace 16. Informant Wash. San. & Hosp. RecordsAddress Takoma Park, Md.17. Removal (Burial, cremation, or removal. Which?) RemovalDate thereof Apr. 2, 1946
(month) (day) (year)Cemetery or crematory Glenwood Cem.Location 18. Funeral director S. H. Penick CompanyAddress 2901-14th St. N.W.

19. April 2nd 46 (Date rec'd by registrar)

Registrar Attest

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/2 1946 at 10¹² A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/14 1946 to 4/2 1946.and that I last saw him alive on 4/2 1946.Immediate cause of death Cardiac dilatation & failure DURATION 3 hrs.
MemoriaDue to Chronic degenerative kidneys several yrs.Due to Other conditions Hypertensive heart disease
Malnutrition marked secondary anemia
(Include pregnancy within 3 months of death)Major findings of operations Date of op. Autopsy results Chronic degenerative kidneys - Hypertensive heart disease
PHYSICIAN: Please underline the cause to which death should be charged statistically. Heart

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE S. Arthur Korb M. D. or other Address Takoma Park, Md. Date signed 4/2/46

RECEIVED

APR 4 1946

BUREAU V S

ARTISTIAN LEONARD

PAGE CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
& birth date of deceased is shown 2411 N. Charles St., Baltimore 32

03916

Reg. Dist. No. 216

on
FILM No. I 01 APR 29 1946

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Suburban HospHow long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 106 Beech Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mrs Julia Kalis

3.(b) Social Security Number

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 19 1875 July 13, 18768. AGE: Years 71 Months 69 Days 9 23 hrs. min.

6.(c) If alive, give age years

9. Birthplace Alpine Michigan
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Michael O'Meara13. Birthplace Ireland14. Maiden name Mora15. Birthplace Ireland16. Informant Nurse Records

Address

17. Removal Date thereof April 12, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location St. Paul, Minn.18. Funeral director Francis J. CollinsAddress 3821-14th St. N.W.19. 4/11 19 46 2pm E Johns
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-11-1946 at 6:40 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1946 to 4-11-1946and that I last saw him alive on 11:40 a.m. 4-11-46

Immediate cause of death

DURATION

Due to ArterioscleroticDue to heart disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations severe coronary sclerosisAutopsy results Severe generalized arteriosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Nowakowski M. D. or otherAddress Suburban Hospital Date signed

RECEIVED
APR 12 1946
BUREAU V. B.

03917

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
City or town Lakoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 38 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Lakoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 7805 Lakoma Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war *yes 1st W. war

3.(a) FULL NAME

Abraham Danziger Kiefer

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Helen Kiefer

7. Birth date of

deceased (mo., day, yr.)

April 11, 1893.

6.(c) If alive, give age

53 years

8. AGE:

Years

52

Months

11

Days

29

If less than one day

hrs. min.

9. Birthplace

Cinn. Ohio
(Town, county, and state)

10. Usual occupation

Chemical Engineer

11. Industry or business

Daniel Kiefer

FATHER

12. Name

Cinn. Ohio

13. Birthplace

Rosa Danziger

MOTHER

14. Maiden name

Raf. Ohio

15. Birthplace

Helen Kiefer

16. Informant

7805 Lakoma Ave, Lakoma Pk. Md.17. Cremation

(Burial, cremation, or removal) (Which?)

Date thereof

Apr. 12, 1946
(month) (day) (year)

Cemetery or crematory

Ph. Lincoln

Location

Pring George G. Maryland

18. Funeral director

The S. A. Jones Co.

Address

2901-14th St. Wash. D.C.19. April 101946
(Date rec'd by registrar)J. D. Danziger

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 10 1946 at 11:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1945 to April 10 1946and that I last saw him alive on April 19 1946

Immediate cause of death

Cerebral embolism

DURATION

30 min

Due to

Medical stenosis

Due to

with auricular

Other conditions

fibrillation

(Include pregnancy within 3 months of death)

Major findings of operations

none

Autopsy results

not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Herbert Bauersfeld M.D.23. SIGNATURE Herbert Bauersfeld M.D.Address 17 Dupont Circle Date signed Apr 10, 1946Wash. D.C.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 12 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

03918

216

Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 hours

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Silver Springs
(If outside city or town limits, write RURAL and give nearest town)Street No. 10000 Kinross Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

LASCO, John Sr.

3. (b) Social Security Number

4. Sex

male

5. Color or race

W-US

6.(a) Single, married, widowed, or divorced

married8.(b) Name of husband or wife Betty Lasco6.(c) If alive, give age 53 years7. Birth date of deceased (mo., day, yr.) Nov. 20, 18938. AGE: Years 52 Months 4 Days 26 If less than one day
.....hrs.min.9. Birthplace Romania
(Town, county, and state)10. Usual occupation Barber

11. Industry or business

12. Name George Lasco13. Birthplace Romania14. Maiden name Helen ? Lasco15. Birthplace Romania16. Informant son: Ensign John Lasco, Jr. USNAddress 10000 Kinross Avenue, Silver Springs, Md.17. burial Date thereof Apr 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenmount Cem.Location Philadelphia, Penn.W. W. Chambers

18. Funeral director

Address 1400 Chapin St., N. W., Wash., D.C.19. 4-16 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 April 46 at 1:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 April 46 to 16 April 46
and that I last saw him alive on 16 April 46Immediate cause of death Hemorrhage cerebral

DURATION

12 hDue to Hypertension, arterial 10 yrsDue to glomerular nephritis indef
chronicOther conditions azotemia

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Arterio disease & cerebral Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury CW Thompson Injured at work?23. SIGNATURE C. W. THOMPSON, Lt. Cdr. (MC) USNR
M. D. or otherAddress USNH Bethesda, Md. Date signed 4-16-46

RECEIVED

APR 25 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75-2

CERTIFICATE OF DEATH

 03919 2/2
 Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Poolesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Poolesville, Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ida May McKaig

3. (b) Social Security Number

4. Sex Female 5. Color or race colored 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Samuel McKaig7. Birth date of deceased (mo., day, yr.) march 18, 1879 8.(c) If alive, give age _____ years8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Frederick Co Md
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

12. Name John Fisher13. Birthplace Frederick Co14. Maiden name Susan Alice Washington15. Birthplace Frederick Co16. Informant Maurice FisherAddress Poolesville Md17. Burial Buried Date thereof 4/19/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MartinsburgLocation near Dickerson18. Funeral director Clarence H DavisAddress Poolesville Md19. April 9 19 46 Charles E. Egan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 - 19 46 at 6:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/22 19 46 to 4/5 - 19 46 and that I last saw him alive on 4/5 - 19 46Immediate cause of death cardiac thrombosis DURATION 2 wks.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE B. J. White, M.D.Address Poolesville, Md. M. D. or other _____Date signed 4/6/46

RECEIVED

APR 11 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

CERTIFICATE OF DEATH

03920

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2400 L'Enfant Square S.E. Wash. D.C.
(If rural, give LOCATION)
2(a) If veteran, name war _____

3. (a) FULL NAME

MEREDITH, David Edmond,

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Haulda Meredith
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 2 June 1985

8. AGE: Years 60 Months 10 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Supv. Southern Office Bldg.

11. Industry or business Smart Sand & Gravel Co.

12. Name David K. Meredith

13. Birthplace (dec) Maryland

14. Maiden name Kate Morris

15. Birthplace (dec) Wash., D.C.

16. Informant wife: Mrs. Haulda Meredith

Address 2400 L'Enfant Square, S.E., Wash., D.C.

17. burial Date thereof 4-6-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Congressional Cemetery

Location Washington, D. C.

18. Funeral director James T. Ryan, R.M.B.

Address 317 Penn., Avenue, S. E., Wash., D.C.

19. 4-3 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

3 April 46 12:08A

20. DATE OF DEATH _____ 19 _____ 21 _____

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 March 19 46 to 3 April 19 46

and that I last saw him alive on 3 April 19 46

Immediate cause of death _____ DURATION _____

Hemorrhage, cerebral 5 days

Due to Arteriosclerosis 25 yrs.

Due to Generalized

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE V B Ballard, for

C. W. THOMPSON, Lt. Comdr. (MC) USNR

M. D. or other _____

Address USNH Bethesda, Md. Date signed 4-3-46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4/10/46

RECEIVED
APR 12 1946
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03921

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
 City or town Wheaton Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? died suddenly while
 Hospital, institution, or street address where death occurred:
riding in car.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County Washington
 City or town Washington D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1629 Columbia Rd N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife George L.

7. Birth date of deceased (mo., day, yr.) June 11 1867 5. (c) If alive, give age _____ years

8. AGE: Years 78 Months 10 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace New Berlin Ill
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Frederick Miller

13. Birthplace Germany

14. Maiden name Francis Dietrich

15. Birthplace Germany

16. Informant Miss Francis M. Miller

Address 1629 Col. Rd. D.C.

17. Burial Date thereof Apr. 31, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ashland Cemetery

Location Ashland, Ill

18. Funeral director The S. H. Pines Co.

Address 2901-14th St. N.W. Wash. D.C.

19. April 17 1946 Josephine W. Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 17 1946 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. med exam case 19____ 19____

and that I last saw him alive on 19____

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Brouhaert M.D.

Address Washington Md

Date signed 4-17-46

RECEIVED
APR 23 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

 0392223
 ★ Reg. Diat. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Tokoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

900 Kennebec Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Tokoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 900 Kennebec Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Frank W. Miller

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Nellie6.(c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) May 21 18668. AGE: Years 79 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace New York
(Town, county, and state)10. Usual occupation Retired Minister

11. Industry or business

12. Name Robert F. Miller13. Birthplace N.Y.14. Maiden name Elizabeth Steiner15. Birthplace N.Y.16. Informant Nellie MillerAddress 900 Kennebec Ave17. Cremation Date thereof April 26 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cremation at LeesLocation Washington D.C.18. Funeral director J. Wm. Lees SonsAddress 380-4th St NW19. April 24 19 46 J. Wm. Lees
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 19 46 at 11 A. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 29th 19 43 to April 23 19 46
and that I last saw him alive on April 23rd 19 46

Immediate cause of death

Cerebral thrombosis

DURATION

3 daysDue to Arteriosclerosis and Hypertension3 yrs + 3 yrs +Due to Chronic Myocarditis2 1/2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wallace J. MoorheadAddress 805 Carroll Ave. M.D. or otherDate signed 4-24-46Tokoma Park 12, Md.

RECEIVED
APR 29 1946
BUREAU V.R.

APR 25 1946

BUREAU V.S.

Evidence for the change of
age is shown on
G 107 9/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

03924

CERTIFICATE OF DEATH

Reg. Dist. No. 2/3

1. PLACE OF DEATH:

County Montgomery
City or town Derwood, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.
City or town Derwood, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

George W. Mobley

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife Mandy Taylor

7. Birth date of deceased (mo., day, yr.) July 3, 1875 6. (c) If alive, give age 62 years

8. AGE: Years Months Days If less than one day
71 7 19 hrs. min.

9. Birthplace Montgomery Co. Maryland
(Town, county and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Henry Clark Mobley

13. Birthplace Montgomery Co.

14. Maiden name Sarah McPherson

15. Birthplace Montgomery Co.

16. Informant Mrs. Clyde Mobley

Address Derwood, Md.

17. Burial Date thereof 4/25/46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Forest Oak Cemetery

Location Elizabethtown, Md.

19. Funeral director Wm. Rauld Pumpfrey

Address Rockville, Maryland

4/23/46 Jessamine D. Bratton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 22 19 46 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 2 19 46 to Apr 21 19 46

and that I last saw him alive on Apr 21 19 46

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Angina Pectoris

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. Rauld Pumpfrey M. D. or other

Address Elizabethtown, Md. Date signed Apr 23, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

APR 25 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

03925

CERTIFICATE OF DEATH

Reg. Dist. No. 213 -

1. PLACE OF DEATH:

County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Boley Moore ⁶⁰⁰

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

—

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

April 1, 1946

8. AGE:

Years

Months

Days

If less than one day

19461

hrs.

min.

9. Birthplace

Rockville, Md.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER
MOTHER

12. Name.....

13. Birthplace

14. Maiden name

Margaret Moore

15. Birthplace

16. Informant.....

Address

17.

(Burial, cremation, or removal) Which?

Date thereof

4-10-46
(month) (day) (year)

Cemetery or crematory

County Home

Location

Rockville, Md.

18. Funeral director

Robert L. Snawder

Address

246 N. Wash. St. Rockville, Md.

19.

(Date rec'd by registrar)

4/9/46 Josephine D. Trotter

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/11 1946 at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death Strangulation

DURATION

Due to Child died of accidental strangulation

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results See

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ?

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

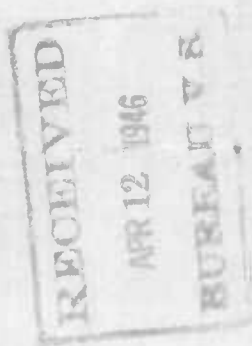
Means of injury

Injured at work?

23. SIGNATURE

Address Sandy Sp... Date signed 4/2/46

not on file.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 99.0

99. a

CERTIFICATE OF DEATH

03926

Reg. Dist. No. ...216.....

1. PLACE OF DEATH: County <u>Montgomery</u> City or town <u>Bethesda, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>10 years -</u> Hospital, institution, or street address where death occurred: <u>557 Grosvenor La., Bethesda, Md.</u> How long in hospital or institution? _____				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Montgomery</u> City or town <u>Bethesda, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>557 Grosvenor La.</u> (If rural, give LOCATION) 2.(a) If veteran, name war _____				
3. (a) FULL NAME <u>Helen C. Morris</u>				3. (b) Social Security Number _____				
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>				
6. (b) Name of husband or wife <u>Edwin B. Morris, Jr.</u>				6. (c) If alive, give age <u>32</u> years				
7. Birth date of deceased (mo., day, yr.) <u>April 2, 1916</u>								
8. AGE: Years <u>30</u>		Months <u>0</u>	Days <u>20</u>	If less than one day _____. hrs. _____. min.				
9. Birthplace <u>Atlanta, Ga.</u> (Town, county, and state)								
10. Usual occupation <u>Housewife</u>								
11. Industry or business _____								
MOTHER	12. Name <u>Martin S. Chandler</u>							
	13. Birthplace <u>Georgia</u>							
	14. Maiden name <u>Elizabeth Telford</u>							
	15. Birthplace <u>Georgia</u>							
16. Informant <u>Edwin B. Morris, Jr.</u>								
Address <u>557 Grosvenor La., Bethesda</u>								
17. <u>Burial</u> (Burial, cremation, or removal. Which?) Date thereof <u>4/24/46</u> (month) (day) (year) Cemetery or crematory <u>Friends Meeting House Cem.</u> Location <u>Sandy Spring, Md.</u>								
18. Funeral director <u>W. R. Hughes, Inc.</u>								
Address <u>Bethesda, Md.</u>								
19. <u>4/24</u> 19 <u>46</u> (Date rec'd by registrar)				Registrar <u>Wm E Jones</u>				
MEDICAL CERTIFICATION								
20. DATE OF DEATH <u>Apr 22</u> 19 <u>46</u> at <u>3:00 A.</u>								
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Dep med Exam</u> 19 <u>46</u> to <u>1946</u> and that I last saw h. <u>alive on</u> <u>Carl</u> 19 <u>46</u>								
Immediate cause of death <u>Acute Myocarditis</u>								
Due to <u>Invol. dead in bed.</u>								
Due to _____								
Other conditions _____								
(Include pregnancy within 3 months of death)								
Major findings of operations _____ Date of op. _____								
Autopsy results _____								
PHYSICIAN: Please underline the cause to which death should be charged statistically.								
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____ Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____								
23. SIGNATURE <u>Frank J. Bronchart M.D.</u> <u>Dep med Exam</u> M. D. or other _____ Address <u>Washington, Md.</u> Date signed <u>4-22-46</u>								

75654

RECEIVED

APR 29 1946

BUREAU V S.

Received

AMERICAN FEDERATION

OF LABOR

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03927

Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery
 City or town Clarksburg
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution:
 Stay in hospital or inst. (yrs., or mos., or days)
 Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Clarksburg Ward No.
 (If outside city or town limits, write RURAL NEAR and give town)
 Street No.
 (If rural give LOCATION) None
 2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME

Frona May Mullinix

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Russell G. Mullinix6. (c) If alive, give age 55 years7. Birth date of deceased (mo., day, yr.) August 12 1890

8. AGE: Years 55 Months 6 Days 27 If less than one day
 hrs. min.

9. Birthplace Montgomery CO. MD.
(Town, county, and state)10. Usual occupation House Wife11. Industry or business Home12. Name George W. Beall13. Birthplace Montgomery CO. MD.14. Maiden name Savania Brown15. Birthplace Montgomery CO. MD.16. Informant Russell G. MullinixAddress Clarksburg MD.17. Burial Date thereof April 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Clarksburg MD.Location Montgomery CO MD.18. Funeral director Roy W. BarberAddress Laytonsville MD.19. April 11 19 46 Della W. Burdette
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 19 46, at 130 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15, 19 46, to April 8, 19 46,
 and that I last saw h. FR alive on April 6, 19 46.

Immediate cause of death Carcinoma of left breast with generalized metastases.
 Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE James P. Kern M.D. M. D. or otherAddress Clarksburg, Md. Date signed 4/10/46

DURATION

3 years

PHYSICIAN

Please underline
 the cause to which
 death should be
 charged statisti-
 cally.

RECEIVED
APR 13 1946
BUREAU V.A.

STATE OF MARYLAND—CERTIFICATE OF DEATH

03928

1. PLACE OF DEATH

County MONTGOMERY

Village or City HYATTSTOWN

Registration Dist. No. 211

No. _____ St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME ARA GERTRUDE MURPHY

(a) Residence: No. HYATTSTOWN MD St. _____ Ward _____

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED

5a. If married, widowed, or divorced

HUSBAND of (or) WIFE of

CHARLES R. MURPHY

6. DATE OF BIRTH (month, day, and year) 11-29-1871

7. AGE Years 74 Months 4 Days 15 If LESS than 1 day, _____ hrs. _____ min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. HOUSE WIFE

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) 4-14-46

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) MONTGOMERY CO. MD.

13. NAME DAVID THOMPSON

14. BIRTHPLACE (city or town) (State or country) MARYLAND

15. MAIDEN NAME SARAH HAWKINS

16. BIRTHPLACE (city or town) (State or country) MARYLAND

17. INFORMANT ANNIS J. CECIL (Address) ROCKVILLE MD.

18. BURIAL, CREMATION, OR REMOVAL Place HYATTSTOWN Date APRIL 16, 1946

19. UNOERTAKER W. A. BURDETTE (Address) HYATTSTOWN MD.

20. FILED April 15, 1946 Della W. Burdette Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April 14, 1946 (Month) (Day) (Year)

22. I HEREBY CERTIFY That I attended deceased from Apr 14, 1946, to Apr 14, 1946

I last saw him alive on Apr 14, 1946; death is held to have occurred on the data stated above, at 3:30 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary thrombosis

Date of onset

Apr 14, 1946

Other Contributory Causes of importance:

Arterio-sclerotic

1936

Name of operation _____ Date of _____ What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State) Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) Ernest P. Roop M. D.

(Address) New Market, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

03929

Evidence for the change of
age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

74a

FILM No. 104 JUN 18 1946 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Cherry Chase
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Cherry Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. #300 Woodbine St Cherry Chase
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Raymond S Harris

3. (b) Social Security Number

4. Sex M 5. Color of race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Label S

7. Birth date of deceased (mo., day, yr.) May 10, 1889 8. (c) If alive, give age 58 years

8. AGE: Years 58 Months 7 Days 11 If less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Sanitary

11. Industry or business

FATHER 12. Name James H Harris
 13. Birthplace Maryland

MOTHER 14. Maiden name Honnie Buttrick
 15. Birthplace Maryland

16. Informant Label S Harris

Address 300 Woodbine St Cherry Chase

17. Removal Removal Date thereof April 29, 1946
 (Burial, cremation, or removal, Which?) (Month) (day) (year)

Cemetery or crematory
 Location Washington D.C.

18. Funeral director Robert A Mattingly

Address 131-114 St SE Wash. DC

19. 4/28 1946 John E Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1946, at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1946, to April 28 1946, and that I last saw him alive on April 28 1946.

Immediate cause of death Acute Dehydrated Heart

Due to Coronary Thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W B Wadrop MD M. D. or other
 Address 943 Bradford St Date signed 4/28/46

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

MAY 3 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

03930

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Days
Hospital, institution, or street address where death occurred:
Naval Hospital Bethesda, Md.
How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D.C. County Washington, D.C.
City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1613 Harvard St. NW Wash., D.C.
(If rural, give LOCATION)
2. (a) If veteran, name war World War I

3. (a) FULL NAME

PATTISON, William Rea Lt. USN Ret. Inact.

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13 1857

8. AGE: Years 89 Months 1 Days 7 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name William Rea Pattison

13. Birthplace Maryland

14. Maiden name unknown

15. Birthplace unknown

16. Informant Mrs. Virginia P. Birgfeld

Address 1613 Harvard St. N.W. Wash., D.C.

17. burial Date thereof 4-23-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director Joseph Gawler Sons ANP

Address 1750 Penna, Ave. NW Washington, D.C.

19. 4-21 46
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 April 19 46, at 4:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 19 46 to 20 April 19 46

and that I last saw him alive on 20 April 19 46

Immediate cause of death Congestive failure

DURATION

4 weeks

Due to Coronary heart disease six months

No evidence of cancer at any time.

Due to The hemorrhage followed the passage of a tube for feeding purposes. Fever

Other conditions Gastric hemorrhage 4 days

of only three to four days' duration.

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

F. E. CHATARD, Comdr. (MC) dUSN

23. SIGNATURE F. E. CHATARD

Address USNH Bethesda, Md. Date signed 4-21-46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

4/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03921 Reg. Dist. No. 1221

FILM No. I O 1 APR 12 1946

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

3.(b) Social Security Number

4. Sex

5. Color or race

6.(b) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

19..46.. at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

RECEIVED

SEP 9 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83d)

CERTIFICATE OF DEATH

03932

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
 City or town Rural Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R. F. D. #2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. County LancasterCity or town Lancaster
(If outside city or town limits, write RURAL and give nearest town)Street No. 735 College Avenue
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

George Washington Pries

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married6. (b) Name of husband or wife Kate Olivia Pries

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 18668. AGE: Years 79 Months 4 Days 17 If less than one day hrs. min.9. Birthplace Conestoga Center, Pa.
(Town, county, and state)10. Usual occupation Retired Fruit Grower

11. Industry or business

12. Name John Pries13. Birthplace Conestoga, Pa.14. Maiden name Mary Frey15. Birthplace Creswell, Pa.16. Informant Harold PriesAddress R. F. D. #2, Silver Spring, Md.17. Shipment & burial Date thereof April 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory M. E. CemeteryLocation Conestoga, Lancaster Co., Pa.18. Funeral director Waxner E. CumpheyAddress Silver Spring, Md.19. 4-14- 19 46 W. L. B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13/46 19 46, at 100 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on

4/10/ 19 46 to 4/13/ 19 46and that I last saw him alive on 4/10/ 19 46

Immediate cause of death

1. Hemiplegia DURATION 6Due to Essential ArterioSclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

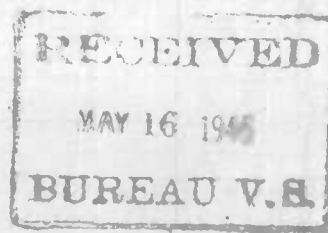
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. L. B. Lawler M. D. or otherAddress Sandy Spring, Md. Date signed 4/14/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

03933

Reg. Dist. No. 2/3.

1. PLACE OF DEATH:

County MontgomeryCity or town Boyd's
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

GORDON GOLDSMITH RAY

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE

WHITE

WIDOWED

6. (b) Name of husband or wife Nannie Page Ray6. (c) If alive, give age deceased years7. Birth date of deceased (mo., day, yr.) July 17, 18768. AGE: Years Months Days If less than one day
69 9 11hrs.min.9. Birthplace Forest Glen, Md.
(Town, county, and state)10. Usual occupation Retired Govt. Employee

11. Industry or business

12. Name Alfred Ray13. Birthplace Petworth, Md.14. Maiden name Eleanore Gatch15. Birthplace Baltimore Co., Md.16. Informant Mrs. James B. MarklandAddress Boyd's, Md.17. Burial Date thereof May 1, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.19. Funeral director W. Reuben HumphreyAddress Bethesda, Maryland19. 4/30/46 Josephine D. Stott
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Boyd's
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2. (a) If veteran, name war No

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 19 46 11:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 46 to Apr 28 19 46and that I last saw him alive on Apr 28 19 46Immediate cause of death MyocarditisDue to HypertensionDue to Diabetes

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John and Mary Hyattsville, Md.Address Hyattsville, Md.M. D. of 4/29/46Date signed 4/29/46

RECEIVED
MAY 3 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

755

03934

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Burtonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 43 yrsHospital, institution, or street address where death occurred:
Farm

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Burtonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Edward Rich

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Ruby - Etta Rich6. (c) If alive, give age 66 years7. Birth date of
deceased (mo., day, yr.)Aug 26 1873

8. AGE:

Years

Months

Days

If less than one day

72726

hrs.

min.

9. Birthplace

Burtonsville, Md
(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

FATHER
MOTHER

12. Name

Wm Rich

13. Birthplace

Bucks Co., Pa

14. Maiden name

Behinda Croardale

15. Birthplace

Bucks Co., Pa.

16. Informant

Ruby Etta Rich

Address

Burtonsville, Md17. Burial
(Burial, cremation, or removal. Which?)

Date thereof

April 24, 1946
(month) (day) (year)

Cemetery or crematory

Union Cemetery

Location

Burtonsville, Maryland

18. Funeral director

Winters & Pappas

Address

257 Carroll St. N. W. Phone Pk. 26

19. Apr 22

(Date rec'd by registrar)

19. 46

Josephine M. Schaffer

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 22, 1946, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med Exam to 19
and that I last saw him alive on case 19

Immediate cause of death

DURATION

Inter-cranial hemorrhage killed

Due to

fracture of skull instantly

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 4-22-46Where did injury occur? Burtonsville, Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) FarmMeans of injury Team of horses ran away Injured at work? yes

23. SIGNATURE

Frank J. Bronckart M. D.
Dep med Exam M. D. or other

Address

Yantherbury, MdDate signed 4-22-46

RECEIVED

APR 25 1946

BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

124-B

03935

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

City.....Montgomery.....

City or town.....Bethesda (rural).....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Va...... County.....

City or town.....Warrenton.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Paul Hamilton RISDON V.B.P.

3.(b) Social Security Number

4. Sex.....male.....
5. Color or race.....W-US.....
6.(a) Single, married, widowed, or divorced.....

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....28 July 1892.....

8. AGE: Years.....53..... Months.....8..... Days.....14.....
If less than one day..... hrs. min.

9. Birthplace.....Virginia.....
(Town, county, and state)

10. Usual occupation.....Veteran.....

11. Industry or business.....

12. Name.....unknown.....

13. Birthplace.....unknown (dec).....

14. Maiden name.....unknown.....

15. Birthplace.....unknown (dec).....

16. Informant.....Mrs. Kate Burke (sister).....

Address.....Warrenton, Va......

17. burial..... Date thereof.....
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....Warrenton, Va......

18. Funeral director.....W. W. Chambers.....

Address.....1400 Chapin St., N.W., Wash., D.C......

19. 4-12..... 46.....
(Date rec'd by registrar)

Registrar.....Mary Charlotte Smith.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....12 April.....46..... at.....1:15 A..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....16 March.....46..... to.....12 April.....46.....

and that I last saw him alive on.....12 April.....46.....

Immediate cause of death.....Right heart failure.....

DURATION.....1 mo......

Due to.....Art. sclerotic heart disease.....

Due to.....2 years.....

Other conditions.....Pneumonia, cirrhosis of liver.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....as above.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Signature.....C. W. Thompson.....

23. SIGNATURE.....C. W. Thompson, Lt. Comdr. (MC) USNR.....

M. D. or other.....

Address.....USNH Bethesda, Md......

Date signed.....4-12-46.....

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4/12/46

RECEIVED
APR 25 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03936 1223
Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

100 Baltimore Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 100 Baltimore Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George James Franklin Roth

3. (b) Social Security Number

183-05-8461

4. Sex

Male

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Mary Alice Stofft Roth6. (c) If alive, give age dead years

7. Birth date of

deceased (mo., day, yr.)

Nov. 11, 1878

8. AGE:

Years

Months

Days

If less than one day

67426

hrs.

min.

9. Birthplace

Burke County, Pa.
(Town, county, and state)

10. Usual occupation

Textile Weaver

11. Industry or business

Textile Business

MOTHER FATHER

12. Name

Matthew Roth

13. Birthplace

Burke County, Pa.

14. Maiden name

Sarah Fegley

15. Birthplace

Burke County, Pa.

16. Informant

Mrs. Maurine Mayberry

Address

100 Baltimore Ave. Takoma Park, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Burial April 10, 1946
(month) (day) (year)

Cemetery or crematory

St. Lincoln Cemetery

Location

Bladensburg Road at D.C. Line

18. Funeral director

Arthur Stalder

Address

254 Carroll St. N.W. Takoma Park, D.C.

19.

(Date rec'd by registrar)

19

Apr. 746

19

William Roth

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946 at 1:34 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. med. exam. 1945 to 1946and that I last saw him alive on exam early 1946

Immediate cause of death

Coronary occlusion

DURATION

dead
sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Broschait M.D.Sept. med. exam.

M. D. or other

Address

Washington, Md.Date signed 4-7-46

RECEIVED
APR 9 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03937 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 15 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 4 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Va. County _____
City or town Staunton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 925 Stewart St.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3.(a) FULL NAME

SAUNDERS, Alto T.

3.(b) Social Security Number

4. Sex male 5. Color or race cl 3-US 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mrs. Margaret Saunders

6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) July 6, 1900

8. AGE: Years 45 Months 9 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Va.
(Town, county, and state)

10. Usual occupation Veteran

11. Industry or business _____

12. Name Archie Saunders

13. Birthplace Va. dec.

14. Maiden name Sallie Brown

15. Birthplace Va. dec.

16. Informant Wife: Mrs. Margaret Saunders

Address 1532 14th St., N.W., Wash., D.C.

17. removal Date thereof 4-18-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Thornrose Cemetery

Location Staunton, Va.

18. Funeral director W. Ernest Jarvis

Address 1432 U Street, N. W., Wash., D.C.

19. 4-19 19 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 April 19 46 at 9:10 on PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Jan 19 46 to 18 April 19 46 and that I last saw him alive on 18 April 19 46

Immediate cause of death _____ DURATION _____

Atherosclerotic 4 mo.

Due to heart disease 4 mo.

2 Hypertension 4 mo.

Also to congestive failure 5 mo.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operation 7 carb. int. calcareous

enlarged heart.

Autopsy results Charles W. Thompson

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury CU Thompson Injured at work? _____

C. W. THOMPSON, Lt. Cdr. (MC) USNH

23. SIGNATURE _____ M. D. or other _____

Address USNH Bethesda, Md. Date signed 4-19-46

MARGIN RESERVED FOR BINDING

I

9-45-1

A15

4/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 3 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03938 6323

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital
 How long in hospital or institution? 1 day 3 hours

3. (a) FULL NAME

Annice Savoy

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1 Railroad Ave
 (If rural, give LOCATION)

2. (d) If veteran, name war

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

William

7. Birth date of deceased (mo., day, yr.)

May 11, 1900.

8. (c) If alive, give age

years

8. AGE:

Years 45 Months 11 Days

If less than one day

8. Birthplace

(Town, county, and state)

10. Usual occupation

maid

11. Industry or business

12. Name

Thomas Tyson

13. Birthplace

md-

14. Maiden name

Annice Tyson

15. Birthplace

md.

16. Informant

Husband

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

4321 W. Sh. N. W. Wash. D.C.

19. 4/12

(Date rec'd by registrar)

29 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 11, 1946, at 10:48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 10, 1946, to April 11, 1946.

and that I last saw her alive on April 11, 1946.

Immediate cause of death

Cerebral accident

DURATION

Due to

Hypertension, essential

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Barbara Manton MD

Address

Date signed April 13, 1946

RECEIVED

APR 20 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03939

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Mont.City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4832 Bradley BlvdHospital, institution, or street address where death occurred: 4 yrs

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Mont.City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 4832 Bradley Blvd
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

MADELINE SCHARF

3. (b) Social Security Number

4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife P. Paul

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 18788. AGE: 67 Years Months Days If less than one day67 hrs. min.9. Birthplace Boston Mass
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name 2m Maria13. Birthplace Unknown14. Maiden name Marion Longfellow15. Birthplace Unknown16. Informant Eugene A. Scharf SonAddress Balt. Md17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Apr 24/46
(month) (day) (year)Cemetery or crematory Rock Creek CemLocation Wash DC18. Funeral director Joseph Hawley SonsAddress 1756 Pa. Ave. N.W.19. 4/21 1946 2m E Jones Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1946 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 20 1946 to April 21 1946and that I last saw her alive on April 20 1946Immediate cause of death Cerebral Embolus

DURATION

Due to Hypertension andArteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Jagers M.D. M. D. or otherAddress 8016 Derry St. N.W. Date signed 4/21/46Bethesda

RECEIVED
APR 27 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 days
 Hospital, institution, or street address where death occurred:
Washington Sen. & Hosp.
 How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 807 Thayer Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Helen Marie Seek.

3. (b) Social Security Number

4. Sex <u>fe</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
6. (b) Name of husband or wife <u>Mr. Charles Seek.</u>		
7. Birth date of deceased (mo., day, yr.) <u>June 13 - 1910</u>		
8. AGE: Years <u>35</u>	Months <u>9</u>	Days <u>20</u>
If less than one day hrs. min.		
9. Birthplace <u>Jersey City - New Jersey</u> (Town, county, and state)		
10. Usual occupation <u>House wife</u>		
11. Industry or business		
MOTHER	12. Name <u>Anton Oscar Lund</u>	
	13. Birthplace <u>Sweden</u>	
	14. Maiden name <u>Selma Carlson</u>	
FATHER	15. Birthplace <u>Sweden</u>	
	16. Informant <u>Washington Sen. Records</u>	
	Address <u>Washington Sant Hosp. Parking</u>	
17. <u>Burial</u> Date thereof <u>April 5, 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year)		
Cemetery or crematory <u>FED. WASH. MEMORIAL CEMETERY</u>		
Location <u>2555 ROAD, HYATTSVILLE, MD. P.R. FED. CO.</u>		
18. Funeral director <u>Arthur Stalass</u>		
Address <u>254 Carroll St. N.W. Washington, D.C.</u>		
19. <u>Apr 3 46</u> Registrar		

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-2-46 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11, 1946 to 4-2-46 and that I last saw her alive on 4-1-46

Immediate cause of death Carcinoma of liver (metastatic)

Due to Carcinoma of right breast

Other conditions Jaundice - Ascites

(Include pregnancy within 3 months of death)

Major findings of operations Not operated this adm.

Autopsy results Refused

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lead H. Calvert MD M. D. or other

Address Silver Spring Md Date signed 4-2-46

RECEIVED

APR 4 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *5d*

CERTIFICATE OF DEATH

03941

Reg. Dist. No. *414*

1. PLACE OF DEATH:

County *Montgomery*

City or town *Silver Spring*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *2nd* County *Montgomery*

City or town *Silver Spring*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *14 Parkside Rd.*
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Virginia Shepard

3. (b) Social Security Number

4. Sex *Female*

5. Color or race *White*

6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *Harry A. Shepard*

8. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) *Jan 5 1864*

8. AGE: Years *82* Months Days It less than one day hrs. min.

9. Birthplace *Wisc.*
(Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business

12. Name *Robert Chichen*

13. Birthplace *England*

14. Maiden name *Prudence Benson*

15. Birthplace *England*

16. Informant *Ruth Shepard*

Address *14 Parkside Rd.*

17. *Removal* Date thereof *April 9, 1946*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location *Washington D.C.*

18. Funeral director *Deal Funeral Home*

Address *4812 Ga. Ave. N.W. D.C.*

19. *Apr. 9* 19 *46* *Josephine M. Kheff*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 9* 19 *46*, at *4:14* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *November 1* 19 *45* to *4-8-46* 19 *46* and that I last saw him alive on *4-8-46* 19 *46*

Immediate cause of death *Ch. myocardial Infarction* DURATION *5 yrs*
Due to *Arteriosclerosis, generalized* *10 yrs*
Due to *Hypertension* *10 yrs*

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE *Andrew J. Bell M.D.* M. D. or other
Address *800 Butterfield St. Wash. D.C. N.W.* Date signed *4-9-46*

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 11 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03943

Reg. Dist. No.

216

1. PLACE OF DEATH:

County... MONTGOMERY

City or town... DRUMMOND, CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 YRS.

Hospital, institution, or street address where death occurred:

4725 DRUMMOND AVE.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... MONTGOMERY

City or town... DRUMMOND, CHEVY CHASE
(If outside city or town limits, write RURAL and give nearest town)Street No... 4725 DRUMMOND AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war... No

3. (a) FULL NAME

WILLIAM D. SHOEMAKER

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife... MARGARET B. SHOEMAKER

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) JUNE 28, 1880

8. AGE: Years Months Days If less than one day

65

9

8

hrs. min.

9. Birthplace... WASHINGTON, D.C.
(Town, county, and state)

10. Usual occupation... ATTORNEY

11. Industry or business

12. Name... THOMAS F. SHOEMAKER

13. Birthplace... WASHINGTON, D.C.

14. Maiden name... JANE A. BLAIR

15. Birthplace... MARYLAND

16. Informant... Mrs Margaret B. Shoemaker

Address 4725 Drummond Ave. Chevy Chase Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 10, 1946
(month) (day) (year)

Cemetery or crematory... MT OLIVET CEMETERY

Location... WASHINGTON, D.C.

18. Funeral director... Francis J. Hollans

Address 3821-14th St. N. W. Wash. D.C.

19. 4/8 1946 Jm Egoles

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 6 1946 at 9:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1939 1939 to April 6 1946

and that I last saw him alive on 4th of April 1946

Immediate cause of death... Hypostatic pneumonia

Due to... Asystole - Myocarditis

DURATION 2 weeks

Due to...

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Harry M. Fletcher M.D.

Address... 4501 Nebraska Ave. Date signed April 7, 1946

RECEIVED

APR 12 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

03942

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 6611 East Avenue
(If rural, give LOCATION)2(a) If veteran, name war No

3. (a) FULL NAME

Mrs. Betty S. Shipley

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Joshua Q. Shipley6. (c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) 18918. AGE: Years 65 Months 0 Days 0 If less than one day
.....hrs.min.9. Birthplace Staunton, Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John A. Whitlock13. Birthplace Virginia14. Maiden name Mary L. Hamm15. Birthplace Virginia16. Informant Mr. James A. WhitlockAddress 5829 Nebraska Ave., N.W.17. Burial Date thereof April 27, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D.C.18. Funeral director W. Reuben ThompsonAddress Bethesda, Maryland19. 4/25 19 46 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 24 19 46 at 11⁴⁰ P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/12/45 19 45 to April 24 19 46 and that I last saw him/her alive on April 24 19 46Immediate cause of death Cerebral hemorrhageDue to Hypertensive Cardiovascular Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. L. Marks, M.D. M. D. or otherAddress 4601 Leland St. Date signed 4/24/46

MINISTRY OF THE INTERIOR

DEPARTMENT OF THE INTERIOR

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

RECEIVED

APR 29 1946

DEPARTMENT OF THE INTERIOR

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

RECEIVED

APR 29 1946

DEPARTMENT OF THE INTERIOR

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

RECEIVED
APR 29 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03944

Reg. Dist. No. 218

1. PLACE OF DEATH:

County.....Montgomery
 City or town.....Boysds MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....fifty years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Maryland County.....Montgomery
 City or town.....Boysds MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....No

3. (a) FULL NAME

Daniel
Theodore Daniel Webster Simmons

3. (b) Social Security Number

No

4. Sex.....Male
 5. Color or race.....White
 6.(a) Single, married, widowed, or divorced.....Widowed

8.(b) Name of husband or wife.....Wiccie B. Simmons

6.(c) If alive, give age.....50 years

7. Birth date of deceased (mo., day, yr.).....April 25, 1876

8. AGE: Years.....69 Months.....11 Days.....21
 If less than one day..... hrs. min.

9. Birthplace.....Frederick CO. MD.
 (Town, county, and state)

10. Usual occupation.....Farmer

11. Industry or business.....Farm

12. Name.....Lewis Simmons

13. Birthplace.....VA.

14. Maiden name.....Josephine Koontz

15. Birthplace.....VA.

16. Informant.....Wiccie B. Simmons

Address.....Boysds MD.

17. Burial Date thereof.....April 20, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Walker Chapel VA.

Location.....Near DC.

18. Funeral director.....Roy W. Barber

Address.....Laytonsville MD.

19. April 19, 46 Charles S. Cooke
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....April 16, 1946 at.....8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....April 2, 1946 to.....April 16, 1946

and that I last saw him alive on.....April 16, 1946

Immediate cause of death.....Bronchial asthma

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Wm. S. Barber
 M. D. or other

Address.....Boysds MD. Date signed.....April 19, 1946

RECEIVED

APR 23 1946

BUREAU V.S.

03945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

10209 Corn Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)Street No. 10209 Corn Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles G. Smith M.D.

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Alfred Smith

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Jan 29 1869

8. AGE:

Years

Months

Days

If less than one day

77211

hrs.

min.

9. Birthplace

Kensington, Md
(Town, county, and state)

10. Usual occupation

physician

11. Industry or business

FATHER

12. Name

Francis W. Schmitt

13. Birthplace

Germany

MOTHER

14. Maiden name

Margaret Schaller

15. Birthplace

Germany

16. Informant

Mrs Everett Davis

Address

Kensington, Md

17.

Burial
(Burial, cremation, or removal, which?)Date thereof April 22 1946
(month) (day) (year)

Cemetery or crematory

Red Bud Cemetery

Location

Red Bud, Illinois

18. Funeral director

The S. H. Hines Co

Address

2901 14 St N.W Wash-DC

19.

4-19-46
(Date rec'd by registrar)

19

W.E. Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 1946 at 6:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept med. Exam Case 1945 to 1946and that I last saw him alive on Sept 19 1945

Immediate cause of death

Coronary occlusion

DURATION

sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Broschard M.D.
Sept med. Exam M. D. or otherAddress Washington, Md Date signed 4-19-46

MARGIN RESERVED FOR BINDING

VS A15 9.45.1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 27 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information, carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03946

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

11220 East Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)Street No. 11220 - East Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Frankford C. Sparshott

3.(b) Social Security Number

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Cornelia Alice

7. Birth date of

deceased (mo., day, yr.)

Aug 30, 1860

8.(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

85

hrs.

min.

9. Birthplace

Camden, New Jersey
(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

Retired

FATHER

12. Name

Samuel

13. Birthplace

England

MOTHER

14. Maiden name

Bullock

15. Birthplace

England

18. Informant

Gordon E. Taylor

Address

11220 - East Ave.

11.

Burial

Date thereof

Apr. 6, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Int Zion

Location

Beltsda, Md.

18. Funeral director

W. W. Chambers Co.

Address

3072 - M - St. N.W.

19.

April 3, 1946

19.46

Josephine M. Schaeffer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....April 3, 1946 at 3:35 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Mar 1, 1946 to April 2, 1946and that I last saw him alive on April 2, 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

3 days

Due to

Hypertensionseveral years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John N. Andrews M.D.

Address

8632 Calverville Rd.
Silver Spring, Md.

M. D. or other

Date signed 4-3-46

CERTIFICATE OF DEATH

RECEIVED
APR 6 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

03947

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:

County MONTGOMERY
 City or town TAKOMA PARK
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 YRS.
 Hospital, institution, or street address where death occurred:
606 CARROLL AVE.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County MONTGOMERY
 City or town TAKOMA PARK
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 606 CARROLL AVE.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Etta M. Spicer

3. (b) Social Security Number

4. Sex Fe 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) JULY 11, 1860

8. AGE: Years 85 Months 8 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace WELLSVILLE, N.Y.
 (Town, county, and state)

10. Usual occupation TEACHER - ARTIST.

11. Industry or business

12. Name AMBROSE C. SPICER.13. Birthplace N.Y.14. Maiden name SUSANA COON15. Birthplace N.Y.16. Informant ELD. W.A. SPICERAddress 606 CARROLL AVE.

17. BURIAL Date thereof APRIL 4, 1946.
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GEO. WASH. MEMORIAL CEMETERYLocation RIGGS ROAD, HYATTSVILLE, MD.18. Funeral director Arthur J. HallidayAddress 254 Carroll St. Takoma Park, D.C.

19. Apr-3 1946
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 2 1946 at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Apr 2 1946
 and that I last saw him alive on March 31 1946

Immediate cause of death Senile myocarditis

DURATION

Due to

Due to

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Silver Spring Md Date signed Apr 2-46

RECEIVED

APR 4 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03948

Reg. Dist. No. 211

1. PLACE OF DEATH:

County MontgomeryCity or town Woodfield
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Two years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town R.F.D. Faithersburg, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Woodfield
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bessie Alice Stup

3. (b) Social Security Number

-4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Maurice F. Stup7. Birth date of deceased (mo., day, yr.) march 13, 1878

8. (c) If alive, give age _____ years

8. AGE: Years 68 Months 1 Days 12 If less than one day _____ hrs. _____ min.9. Birthplace md
(Town, county, and state)10. Usual occupation Housewife11. Industry or business home12. Name George W. Dashner13. Birthplace West Va14. Maiden name Sarah W. Dashner15. Birthplace West Va.16. Informant Maurice F. StupAddress Faithersburg17. Burial Date thereof April 28, 1946
(Burial, cremation, or removal. Which? month) (day) (year)Cemetery or crematory St. Lukes Lutheran ChurchLocation Redland md.18. Funeral director J. B. Beall, Inc.Address Damascus md.19. April 27, 1946 Registrar Della W. Burdett
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1946 at 7:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16, 1943 to April 25 1946and that I last saw him alive on April 24 1946Immediate cause of death Chronic glomerular nephritis

DURATION

2 yearsDue to Rheumatic cardio-vascular disease 20 years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE James P. Kerr, M.D.

M. D. or other

Address Damascus, Md.Date signed 4/27/46

RECEIVED MAY 2 1946

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

County of ...

City of ...

Name of Deceased ...

Age ...

Sex ...

Marital Status ...

Occupation ...

Place of Birth ...

Date of Death ...

Time of Death ...

Place of Death ...

Cause of Death ...

Signature of Physician ...

Signature of Coroner ...

Signature of Registrar ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

Signature of ...

RECEIVED
MAY 2 1946
BUREAU V

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03949

Reg. Dist. No. 213

1. PLACE OF DEATH:

County MontgomeryCity or town Rockville Homers Lane RFD #4
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. Horners Lane, RFD #4
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Joseph Franklin Taylor

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife None

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) October 23, 1887

8. AGE:

Years

Months

Days

If less than one day

5858

hrs.

min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name James O. Taylor13. Birthplace Baltimore, Md.

MOTHER

14. Maiden name Mary E. Higgins15. Birthplace Carroll Co., Md.16. Informant Charles W. TaylorAddress RFD #4, Rockville, Md. Horners Lane17. Burial Date thereof April 3, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Potomac Methodist Ch. Cem.Location Potomac, Maryland18. Funeral director Wm. Andrew RungbergAddress Rockville, Maryland19. 4/2/46 19.....

Date received by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 1 1946 at 2:00 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945 to 1946 and that I last saw him alive on Sept. 1945

Immediate cause of death

Coronary occlusion

DURATION

Formal
dissection

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Broschart M.D.
Smithsburg Md. Date signed 4-1-46

RECEIVED

APR 5 1946

BUREAU V &

Evidence for change of age is shown on **MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore 73-a

03950

FILE No. I O 1 MAY - 2 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 551 24th St., N.E.

(If rural, give LOCATION)

2(a) If veteran, name war 1st World War

3. (a) FULL NAME

THOMAS, Henry (n)

3. (b) Social Security Number

4. Sex male

5. Color or race Colored

6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 July 1886

8. AGE: Years 59 Months 69- Days 8 If less than one day 29 hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation veteran

11. Industry or business

12. Name Henry Thomas

13. Birthplace Md. (dec.)

14. Maiden name Henertia Carter

15. Birthplace Md. (dec.)

16. Informant daughter: Miss Ramona Thomas

Address 551 24th St., N.E., Wash., D.C.

17. burial Date thereof (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director George B. Clark &

Address 1416 Florida Avenue, N.E., Wash., D.C.

19. 4-1 46 Mary Charlotte Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 19 46 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

23 March 19 46 to April 1 19 46

and that I last saw him alive on 1 April 19 46

Immediate cause of death

Acute Myocarditis

DURATION

3 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury C. W. Thompson Injured at work?

23. SIGNATURE C. W. THOMPSON, LT. Comdr. (MC) USNR

M. D. or other

Address US NH Bethesda, Md. Date signed 4-1-46

MARGIN RESERVED FOR BINDING

VS A15 9.45

4/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DD
APR 25 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

03951

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Brighton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Brighton
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Clavard W. Thompson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

December 25, 1842

6. (c) If alive, give age _____ years

8. AGE:

108 Years

Months

4

Days

3

It less than one day

hrs. min.

9. Birthplace

Frederick, Maryland
(Town, county, and state)

10. Usual occupation

Laborer.

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

5-1-46

(month) (day) (year)

Cemetery or crematory

Sandy Spring Ceme.

Location

Sandy Spring, Md.

18. Funeral director

Robert L. Snawder

Address

246 N. Wash. St. Rockville

19.

4-29-46

(Date rec'd by registrar)

Robert L. Snawder

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 19 46, at 11:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. med. exam. case to 19and that I last saw him alive on 19

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Frank J. Bruchman M.D.Sept. med. exam. M. D. or otherChesapeake Md. Address _____Date signed 4-29-46

DURATION

deathstudy

RECEIVED

MAY 16 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

43952 216
Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery CoCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

in ambulance on way to Hospital

How long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County D.C.City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 4115 - Harrison St. N.W.
(If rural, give LOCATION)2.(a) If veteran, name war WW

3. (a) FULL NAME

William Earle Torrens

3. (b) Social Security Number

WW4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife Single7. Birth date of deceased (mo., day, yr.) Sept 6, 1898 6.(c) If alive, give age 46 years8. AGE: Years 47 Months 0 Days 0 If less than one day 0 hrs. 0 min.9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation Mail Clerk11. Industry or business U.S. Government12. Name William Torrens13. Birthplace Washington D.C.14. Maiden name Katherine Smith15. Birthplace Washington D.C.16. Informant Paul TorrensAddress 4115 - Harrison N.W.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof April 8, 1946
(month) (day) (year)Cemetery or crematory Mt. Olivet CemeteryLocation Bladensburg Road N.E. Wash. D.C.
(C.A. Adams)18. Funeral director Cherry Chase Funeral HomeAddress 5103 - Wisconsin N.W. D.C.19. 4/6 46 7pm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1946 at 9:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4, 1946 to April 4, 1946and that I last saw him alive on 4-7 1946

Immediate cause of death

Congestive heart failure
MYO CARDITIS, acute

DURATION

Due to Duration: 2 weeksDue to Exhaustion, lack of cardiac output

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. P. Andrews M.D. M. D. or otherAddress 4201 Fessenden St. N.W. Date signed 4-4-46

MONTGOMERY CORNER NOTIFIED & APPROVED

RECEIVED

APR 12 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County MontgomeryCity or town Kensington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

on Street near 9400 Conn. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Colesville
(If outside city or town limits, write RURAL and give nearest town)Street No. R. F. D. 1 Silver Spring
(If rural, give LOCATION)2.(a) If veteran, name war no

3. (a) FULL NAME

Francis E. Valdeman

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mary Craver

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mar. 21st. 18868. AGE: Years 60 Months 0 Days 26 If less than one day _____ hrs. _____ min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Tree Surgeon11. Industry or business Mont. Co. Commissioners12. Name William Valdeman13. Birthplace Maryland14. Maiden name Louise Kemp15. Birthplace Maryland16. Informant Mrs. Mary C. ValdemanAddress R.F.D. 1 Silver Spring17. Burial Burial Date thereof Apr. 20-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Colesville M. E.Location Colesville, Md.18. Funeral director Wm E PumphreyAddress Silver Spring, Md.19. Apr. 19 19 46 Joseph W. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 17 1946 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1941 to 1946and that I last saw him alive on 1946

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brockett M.D. M. D. or otherAddress Silver Spring, Md. Date signed 4-17-46

RECEIVED

APR 23 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 994

CERTIFICATE OF DEATH

03954

Reg. Dist. No. 213

1. PLACE OF DEATH:

County MontgomeryCity or town Buck Lodge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Buck Lodge, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Zourie Pretzman Wade

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

8.(b) Name of husband or wife

Mr. Eugene Wade

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

1864 9

8. AGE:

Years

Months

Days

If less than one day

82 9

hrs.

min.

9. Birthplace

Middleton, Indiana Co. Ind.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Crawford James

13. Birthplace

Maryland

MOTHER

14. Maiden name

Mary Ellen Pretzman

15. Birthplace

Indiana

16. Informant

Beryl Wade

Address

Burg, Maryland

17. (Burial, cremation, or removal. Which?)

BuriedDate thereof 4/15/46
(month) (day) (year)

Cemetery or crematory

Beallsville Ind.

Location

Beallsville Ind.

18. Funeral director

William B. Hill

Address

Bearsville Ind.

19. (Date rec'd by registrar)

4/14 1946 Mr. C. C. Hiltner
By Mr. W. A. H. Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13th 1946, at 5 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 to April 13th 1946and that I last saw him alive on April 12th 1946Immediate cause of death Cerebral Hemorrhage DURATION 12 hrs(Left Hemiplegia)Due to General arterial sclerosis

Due to _____

Other conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Upton D. House M.D. M. D. or other _____Address Davensville Md. Date signed 4/13/46

RECEIVED

APR 20 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

03955

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
County White Oak Md.
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County White Oakes
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Mary Washington

3. (b) Social Security Number

4. Sex 7 5. Color or race Col. 8.(a) Single, married, widowed, or divorced Wid.

6.(b) Name of husband or wife Adam Washington

6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) Sept 8, 1872

8. AGE: Years 73 Months Days If less than one day
..... hrs. min.

9. Birthplace White Oak, Md.
(Town, county, and state)
None

10. Usual occupation.....

11. Industry or business

FATHER 12. Name Frank Mahean

13. Birthplace Montgomery Co. Md.

MOTHER 14. Maiden name Christie Mahean

15. Birthplace Colesburg, Md.

16. Informant Mrs E. Carter

Address White Oak, Md.

17. (Burial, cremation, or removal) Which? Date thereof May 2, 1946
(month) (day) (year)

Cemetery or crematory Good Hope Md.

Location Charles B. Cooper

18. Funeral director Charles B. Cooper

Address 512 N. Commercial, Balt. Md.
Commodore Baltimore Md.

19. Apr. 30 19 46 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 19 46 at 2:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1, 19 46, to April 29 19 46
and that I last saw him alive on April 28 19 46

Immediate cause of death Chronic Myocarditis DURATION 1 year

Due to myocardial heart failure

Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Calvin B. Le Comte M. D. or other
Address White Oak Md Date signed 4/29/46

RECEIVED BY TELETYPE UNIT CHAIRMAN

STATE OF TEXAS

DEPARTMENT OF COMMERCE

STATE OF TEXAS

RECORDED
MAY 3 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117-E

03956

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 hrs.
Hospital, institution, or street address where death occurred:
Suburban Hosp. - Bethesda, Md.
How long in hospital or institution? 16 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D County Washington D.C.
City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3723 Morrison St. N.W.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Mr Fred B Watt

3. (b) Social Security Number

414-03-2964

4. Sex 82 5. Color or race W 6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife MARY Watt 8. (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1863

8. AGE: Years 82 Months 4 Days 12 If less than one day hrs. min.

9. Birthplace Moline, Illinois
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name William Watt

13. Birthplace Illinois

14. Maiden name Elizabeth William

15. Birthplace Illinois

16. Informant Mrs. Mary S. Watt

Address 3723 Morrison St. N.W.

17. Shipment Date thereof 4/23/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Lawn Cemetery

Location Moline, Illinois

18. Funeral director Wm Reuben Pumphrey

Address 7557 Wis. Ave. Bethesda, Md.

19. 4/23, 46 Jm E Jones
(Date rec'd by registrar) registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 46 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 19 46 to April 22 19 46
and that I last saw him alive on April 22 19 46

Immediate cause of death

CHRONIC DUODENAL ULCER WITH
RUPTURE AND ACUTE PERITONITIS

Due to

Due to

Other conditions ACUTE ABSCESS OF
SUBENDOCARDIUM OF LEFT VENTRICLE
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results AS. ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Watt E. De Lawter MD M. D. or other

Address Suburban Hosp Bethesda Md. Date signed Apr 23, 1946

MARGIN RESERVED FOR BINDING

VS A15

9.45-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

APR 29 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 172

CERTIFICATE OF DEATH

03957

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day + 16 1/2 hrs.
 Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
 How long in hospital or institution? 1 day + 16 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Silver Spring
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 801 Forest Glen Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Wood - ~~unnamed~~ Joel Harold

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age _____ years

April 17, 1946

8. AGE: Years Months Days If less than one day

16 hrs. 30 min.9. Birthplace Takoma Park, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Harold Aldo Wood13. Birthplace Madison, N. J.14. Maiden name Elizabeth Janice Penrod15. Birthplace Koten, Kansas18. Informant Washington Sanitarium Hosp. RecordsAddress Takoma Park, Maryland17. Burial Date thereof 4-20-46
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory St. Lincoln CemeteryLocation Prince Georges Co., Md.18. Funeral director Arthur WaltersAddress 254 Carroll St. N.W. Wash. D.C.19. Apr. 17, 1946
(Date read by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

2D. DATE OF DEATH 4-19-46 at 1:20 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-17-46 to 4-19-46 and that I last saw him alive on 4-19-46

Immediate cause of death

Cesphyxiation

DURATION

Due to

anoxia

Due to

congenital heart?from birth

Other conditions

Atelactasis left2 daysupper lobe
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or otherAddress 800 Woodbury Dr Date signed 4/19/46

RECEIVED

APR 23 1946

BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County MontgomeryCity or town Dickerson
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.City or town Beallville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Stella Maude Young

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Hewlyn Young

7. Birth date of

deceased (mo., day, yr.)

March 20, 1877

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

69011

hrs.

min.

9. Birthplace

Fredrick Co. Md.
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

Theodore Davis

12. Name

Md.

13. Birthplace

unknown

14. Maiden name

unknown

15. Birthplace

Beallville, Md.

16. Informant

Burial

(Burial, cremation, or removal. Which?)

Date thereof

4446

(month) (day) (year)

17. Cemetery or crematory

Monocacy

18. Location

Beallville, Md.

19. Funeral director

Tom B. Hilton

20. Address

Barneville, Md.19. Apr. 3 19 46 Mrs. C. C. Hilton
(Date rec'd by registrar) By Mrs. W. B. Hilton

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1st 19 46 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 11 19 46 to April 1 19 46and that I last saw him alive on April 1 19 46

Immediate cause of death

Cerebral Hemorrhage

DURATION

21 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Byron D. White, M.D.Address Beallville, Md. Date signed 4/2/46

RECEIVED

APR 9 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 03959 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month 8 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 1 month 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State N.Y. County _____City or town Brooklyn
(If outside city or town limits, write RURAL and give nearest town)Street No. 504 Hendrix St.
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

ZWILLENBERG, Irwin Harold,

3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>Jewish</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
-----------------------	-----------------------------------	--

8. (b) Name of husband or wife Mrs. Sophie Zwillenberg

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 7-25-25

8. AGE:	Years	Months	Days	If less than one day
	<u>20</u>	<u>9</u>	<u>3</u>	_____ hrs. _____ min.

9. Birthplace N.Y.
(Town, county, and state)10. Usual occupation Farming

11. Industry or business _____

12. Name Max W. Zwillenberg13. Birthplace N.Y.14. Maiden name Sadie M. ?15. Birthplace N.Y.16. Informant wife: Mrs. Sophie ZwillenbergAddress 504 Hendrix St., Brooklyn, N.Y.17. removal Date thereof 4-29-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Montefiore CemeteryLocation Long Island, N.Y.18. Funeral director Barnard DanzanskyAddress 3501 14th St., N. W., Wash., D.C.19. 4-29 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 April 19 46, at 6:21 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 March 19 46, to 28 April 19 46and that I last saw him alive on 28 April 19 46Immediate cause of death HemolyticStreptococcus septicemiaDURATION 5 daysDue to E. oflative dermatitis 6 mos.Due to Psoriasis 3 years

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none performed

Date of op. _____

Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Car Injured at work? Yes23. SIGNATURE E. E. BARKSDALE, Comdr. (MC) USNR
M. D. or other _____Address USNH Bethesda, Md. Date signed 4-28-46

RECEIVED

MAY 3 1946

BUREAU V E